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THE BENEFIT STRUCTURE OF PRIVATE HEALTH INSURANCE 1968

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE / Social Security Administration / Office of Research and Statistics / Research Report No. 32

THE BENEFIT STRUCTURE OF PRIVATE HEALTH INSURANCE, 1968

by LOUIS S. REED
and WILLINE CARR

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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FOREWORD

The growth of private health insurance in the United States during the last 30 years has been dramatic. This insurance now gives some measure of security to most of the population against potentially burdensome or catastrophic hospital and medical costs and is a most important factor in the financing of health care in the United States. At the end of 1968, four-fifths of the population under age 65 had some protection against hospital or other medical costs through private health insurance.

On the face of it this is an impressive statistic. But how broad and deep is this protection? What are the benefit levels under this insurance? The exclusions and exceptions? How much of hospital and medical costs does this insurance actually cover? To what extent is comprehensive health insurance protection available and, if available, purchased? These are the questions this report will help answer. By providing a description of the situation in 1968, it establishes a benchmark against which change in future years, as shown by subsequent reports of the same nature, can be measured.

The monograph makes a detailed analysis of the most widely held contracts of each of the 70 odd Blue Cross and Blue Shield plans; describes the benefits offered by insurance companies under group and individual policies; analyzes the most widely held contracts of the larger community group practice and individual practice plans; and describes the coverages provided by other health benefit plans—employer-employee-union self-insured programs, private medical and dental group clinic plans, and dental service prepayment plans sponsored by dental societies.

The authors wish to thank the various plans, organizations, and insurance companies that provided copies of contracts, policies and other descriptive material, and whose cooperation made the study possible.

Louis S. Reed is a member of the staff of the Division of Economic and Long Range Studies of the Office of Research and Statistics. Miss Willine Carr was also a member of the staff at the time the report was in preparation. Their work was carried out under the immediate supervision of Alfred M. Skolnik. Robert Marsh and Dorothy Belzer of the Publications Staff had responsibility for editing the text and tabular material.

Ida C. Merriam,

Assistant Commissioner for Research and Statistics.

February 1970.

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Chapter 1

INTRODUCTION

THIS REPORT describes the benefit provisions of private health insurance organizations in the United States as of early 1968. Its purpose is two-fold. First, to set forth the nature and scope—types of care covered, extent and duration of benefits, disease restrictions or exclusions—of health insurance coverages currently offered to the public. Second, to establish a benchmark so that subsequent studies will be able to measure change in the future. The study is limited to benefits available to persons under age 65, since virtually all persons aged 65 and over are covered under the Government's Medicare program and private health insurance coverages for this age group complement the Medicare coverages.

Depending on the source of the estimates, some 134 to 154 million Americans under age 65—75 to 87 percent of the total population of this age—have some private health insurance.[1] Yet there are only scattered and limited sources that detail what these persons are receiving in the way of benefits and services. The need for a comprehensive study of the nature and adequacy of prevalent levels of coverage is evident.

The report, in a sense, complements the articles on private health insurance coverage and finances that appear annually in the *Social Security Bulletin*. These articles provide estimates of the number of persons with some coverage of each of 10 salient items of health care. This report gives data on the content of these coverages.

Successive chapters deal with the coverages offered by each type of health insurance organization. The chapter on Blue Cross plans contains tabulations and analyses of the benefits provided by the most widely held group contracts, as of early 1968, of each of the 75 plans in the United States. Copies of these contracts were provided to the Office of Research and Statistics by the Blue Cross Association. The study of Blue Shield coverages is similarly based on an examination of the most widely held contracts of each of the 72 plans in this country, as of early 1968.

A similar approach could not be used in describing the coverages offered by insurance companies under their group policies because of the multiplicity of policies and coverages offered. This section, therefore, describes typical group coverages offered, based on material made available to ORS in early or mid-1968 by the 10 largest writers of group health and accident insurance. Similarly, the chapter dealing with individual health insurance policies offered by insurance companies describes typical policies, and is based on material made available by the 9 largest writers of individual health insurance coverages.

The coverages made available by other types of health insurance organizations—the so-called independent plans—were dealt with as seemed most appropriate and feasible in each case. This section includes (a) an analysis of the benefits provided under the most widely held contract, as of early 1968, of each of the nine largest community group practice plans; (b) a description of the benefits provided under the most widely held contract of the largest community individual practice plan and brief summaries of the contracts offered, as of early 1969, by its affiliated dental insurance plan; (c) descriptions of the benefits offered by two large self-insured employer-

[1] Louis S. Reed and Willine Carr, "Private Health Insurance in the United States, 1967," *Social Security Bulletin*, February 1969.

employee-union plans; (d) a statement of the benefits under a typical contract of the largest private medical group clinic plan; (e) a description of the general types of contracts offered by dental service corporation plans (plans sponsored by dental societies) and a summary of typical contracts offered by the largest plan of this type; and (f) a description of the benefits provided under a typical contract offered by one private dental group clinic plan.

Inasmuch as subscription or premium rates are a vital element in the picture, an endeavor has been made throughout to provide these data for the various types of organizations.

It is impossible to appraise the coverages offered by the different types of health insurance organizations without having in mind some standard of what health insurance coverage is needed. This is something on which there is considerable difference of opinion although a consensus appears to be beginning to develop. The final chapter proposes a standard of health insurance coverage needed by the public, measures existing coverages against this standard, and discusses briefly the reasons why existing coverages fall short of this standard.

Chapter 2

BLUE CROSS PLANS

Most blue cross and Blue Shield plans serving a particular area are affiliated with each other. Their offerings complement each other and are generally sold to the public as a single package. Since most plans are jointly administered, at least in part, they necessarily have common features. Hence a common introduction will serve for the examination of the most widely held Blue Cross and Blue Shield group contracts.[1]

Most Blue Cross plans offer a considerable variety of group contracts and most Blue Shield plans offer at least two. The most widely held contract is defined as the one that covers more persons than any other. It should be understood that in some cases the most widely held contract is such by a narrow margin and that not infrequently it covers less than a majority of the plan's total membership.

Copies of each plan's most widely held group contract were provided to the Office of Research and Statistics by the Blue Cross Association and the National Association of Blue Shield Plans. In some instances, clarifying or supplementary information was obtained from the *Blue Cross Manual* published by the Blue Cross Association and the *Blue Shield Manual* published by the National Association of Blue Shield Plans. Both manuals provide descriptions of the various contracts offered by the plans together with data on subscription rates. When required, additional information was obtained from the Blue Cross Association and the National Association of Blue Shield Plans.

[1] Tables in this report are grouped at the end of each chapter.

Analysis and tabulation of the provisions of the contracts was a difficult, complicated, and time-consuming task. In some cases the provisions of the contracts were not completely clear and judgment had to be exercised with respect to meaning. While it is possible that some errors of interpretation or analysis were made in the case of individual plans, it nevertheless is believed that the summary picture here presented is substantially valid.

In addition to the analysis of the contracts of the individual Blue Cross and Blue Shield plans, a supplementary section summarizes the benefits provided under the high option of the Government-Wide Service Benefit Plan offered jointly by Blue Cross and Blue Shield to Federal employees under the Federal Employees Health Benefits program. This contract probably constitutes the most comprehensive coverage offered jointly by Blue Cross-Blue Shield on a national basis.

Analysis of the benefit structure of Blue Cross and Blue Shield plans could have been made in a number of ways. Analysis of all group contracts offered by the plans would have been an unnecessarily long and complex undertaking. A study of the most comprehensive contract offered by each plan would have had value in indicating the direction in which plans are tending, but would have presented an unrealistic picture of the coverages currently held by the majority of subscribers. All in all, it seemed that analysis of the most widely held group contract of each plan would provide the best picture of the coverages currently in force.

An analysis of the most widely held nongroup contracts would also have had value, but would have taken more time than was available. Group coverages are by far the more important, embrac-

ing about 85 percent of the total membership of both types of plans.[2]

Table 2–1 presents data on the total enrollment of each plan as of December 31, 1967, the monthly subscription rate for the contract in question (as of early 1968), the room accommodations or room allowances provided, any deductible and/or "co-pay" provisions, and the allowances for better accommodations. The data on enrollment are provided so that the reader may gauge the relative importance of the different plans from the standpoint of the number of people served. The enrollment under the specific contract described was not obtained.

Subscription Rates

Data on subscription rates could not be provided for about one-third of the plans. This is because these plans offer a number of contracts that are identical except for the number of days of coverage provided or the amount of the daily room allowance, with the subscription rate varying accordingly. Neither the precise number of days of coverage nor the dollar allowance is stated in the contract itself, but is shown on the subscriber's identification card and the plan's records. It was not considered worthwhile to ask the Blue Cross Association to query these plans as to which of the benefit durations or room allowances were held by the largest number of subscribers—indeed, in many cases the plan itself would not have this information. In a few instances specific subscription rates could not be cited because the plan experience rates all groups and does not publish its initial rates.

Among the 43 plans for which the subscription rate for the most widely held contract could be determined, the monthly rate for a single person generally ranged from $4 to $7. The median rate was $5.67. The monthly subscription rate for a family ranged from about $9 to $21. The most common family rate was in the range of $10 to $12 and the median was $12.22. Only about one-fourth of the plans had a rate for two persons as distinct from that for a family. The distribution of plans by monthly subscription rate is as follows:

Rate	*Plans*
All plans	75
One person:	
Rate not available	32
Under $3	2
$3 to $3.99	7
$4 to $4.99	8
$5 to $5.99	12
$6 to $6.99	6
$7 to $7.99	1
$8 to $8.99	6
$9 to $9.99	1
Median rate	$5.67
Family:	
Rate not available	32
$8 to $9.99	6
$10 to $11.99	14
$12 to $13.99	9
$14 to $15.99	5
$16 to $17.99	6
$18 to $19.99	1
$20 to $21.99	2
Median rate	$12.22

Accommodations Provided

Of the 75 plans, 50 under their most widely held contract provide care in specified accommodations—43 in semiprivate accommodations, four in ward accommodations, and three in either semiprivate or ward accommodations, as the subscriber elects.[3] Five plans provide care in either semiprivate or ward accommodations or give a dollar room allowance, which the contract itself did not specify. Two other plans cover charges for care in semiprivate or ward accommodations up to a daily room allowance. (From this point on, for the sake of simplicity, the present tense is generally used in describing the contract provisions; the past tense would, of course, be more accurate.)

Eighteen plans provide a dollar room allowance only. Most of these offer a wide range of such allowances. This enables the subscriber group to select a room allowance that will approximate the charge for semiprivate or ward accommodations in the hospitals in the locality.

[2] Not counting holders of complementary-to-Medicare contracts.

[3] In the case of these plans the accommodations selected would be shown on the subscriber's identification card and plan records—the contract itself did not specify.

Deductible and 'Co-Pay' Provisions

Ten plans have deductible features in their most widely held contracts. Seven of these have a definite deductible—the amount being generally $25. The other three plans give the subscriber a choice of having or not having a deductible. The subscriber's choice is entered on his identification card and in the plan's records, but is not shown in the contract itself.

Four of the 75 plans have a "co-pay" provision in their most widely held contract, i.e., the subscriber must pay a specified amount for each day of hospitalization. In two plans, the subscriber pays $5 a day for the first 15 days of care; in a third plan he pays $2.50 for the first 20 days; and in the fourth plan he pays 20 percent of all hospital charges, the plan taking care of the remainder.

Allowance for Better Accommodations

When a hospitalized subscriber desires care in accommodations that are better than those to which his contract entitles him, virtually all plans provide that he will receive an allowance against the room charge for the accommodations selected equal to the hospital's average charge for the room accommodations specified in his contract. In virtually all plans he receives the special services covered by his contract. The subscriber entitled to a dollar room allowance, of course, gets this allowance against the hospital's charge for whatever accommodations he uses.

There are some regional variations in benefit patterns. In New England, all the plans except one provide dollar room allowances under their most widely held contract; the exception provides either semiprivate accommodations or a dollar room allowance. All of the plans in the Middle Atlantic area provide care in either semiprivate or ward accommodations. The same is true of virtually all plans in the North Central area. In the South, many of the plans provide dollar room allowances.

Days of Care Covered for General Illness

Table 2–2 shows the days of care provided for general illness, mental illness, and tuberculosis. For general illness the number of days of care provided at full benefits, under the most widely held contract, ranges from 21 to 365. Eight plans provide 30 or 31 days, 18 plans provide 70 days, and 27 give 120 or 125 days of care per admission. In the case of 12 plans, the most widely held contract did not specify the number of days of care, this being shown only on the identification card and the plan's records.[4] The distribution of plans by number of days of full benefits follows:

Days	*Plans*
All plans	75
Not specified	12
21	2
30 or 31	[1] 8
60	1
70	18
90 or 100	2
120 or 125	27
180	1
365	2

[1] 3 of these plans provide 40 days the second year of membership, 50 days in the third year, 60 days in the fourth year, and 70 days in the fifth and subsequent years.

Eight plans provide additional days of care at partial benefits after the days of full benefit have been exhausted. One plan provides 100 additional days at full benefit but with the subscriber paying $3 for each such day of care. Another provides 60 days at half benefits, another 180 days at half benefits. Several provide from 80 to 245 additional days at stipulated—rather small—amounts per day. Details are shown below:

Additional Days of Care	*Plans*
All plans	8
100 days at full benefits less $3 a day	1
60 days at 50 percent	1
180 days at 50 percent	1
80 days at $5 a day	1
90 days at $10 a day	1
245 days at $5 a day	1
180 days at $3 a day	1
365 days in member general hospitals up to a limit of $7,500	1

[4] For these 12 plans the Blue Cross Association provided specific information on the duration of benefits most widely held. In one plan this was 21 days, in another 30 days, in three 70 days, in four 120 days, and in three 365 days.

Almost all Blue Cross plans provide that any readmission to a hospital occurring within a specified number of days of discharge is considered as a continuation of the former admission; any admission after the specified number of days since discharge is considered as a new admission. Of the 75 plans, 66 provide 90 days as the cutoff point, i.e., any admission occurring after 90 days of discharge is treated as a new admission. Four plans specify 60 days and three, 30 days. One plan requires only an interval of 7 days and one has no such requirement, each and every admission being considered as a new admission.

A few plans qualify or broaden these provisions in one way or another. Several plans tighten the provision by specifying that during the 90 or 60 days required for a new admission, the patient must not have been a patient in a nursing or convalescent home or sanitarium. The Rhode Island plan broadens it by providing that any admission for maternity, complications of pregnancy, or an injury shall be considered to be a new admission irrespective of any previous hospital episodes. Others broaden it by specifying that the 90-day requirement shall apply only for the same or a related condition, i.e., any admission for a new or unrelated condition is covered at full benefits, irrespective of any previous hospitalization. Two plans in the West provide that when an employee returns to work on a full-time basis, any subsequent admission is considered as a new admission. A few plans in the West provide that any admission for an accident is considered as a new admission. The Los Angeles plan provides that in the case of the employee subscriber only 28 days must intervene between discharge and admission for the admission to be considered as a new one, whereas a 90-day interval is required in the case of the family member.

Benefits for Mental Illness

In general the plans provide considerably less extensive benefits for mental illness or tuberculosis than for general illness and they provide markedly lower benefits for either mental disease or tuberculosis in mental or tuberculosis hospitals than in general hospitals.

As regards mental illness cared for in general hospitals, 13 plans provide the same benefits as for general illness; the remainder provide fewer days of care than for general illness. Eleven plans provide no benefits whatever for mental illness in general or other hospitals and 10 provide no more than 20 or 21 days. Fewer than one-fifth of the plans provide 60 or more days for mental illness in general hospitals whereas four-fifths of all plans (whose contracts specify duration of benefits) provide 60 or more days for general illness. The distribution of plans by number of days of care provided for mental illness in general hospitals is set forth below:

Days	*Plans*
All plans	75
Not specified	2
Zero	11
Less than 20	5
20–21	5
30–31	38
35	1
60	1
70	4
120–125	8

In general, the plans use a different basis for determining duration of benefits for mental illness than for general illness. Of the plans providing benefits for mental illness in general hospitals, 17 stipulate that any readmission within 60 or 90 days will be considered to be a continuation of the former confinement. In other words, these plans have a provision similar to that of most of the plans for general illness.

By contract, six plans stipulate that any admission for mental illness within 180 days shall be considered as a continuation of the former admission. This, of course, has the effect of reducing the possible days of benefits. Two plans do the same for any readmission within 365 days. Other plans achieve the same result by different types of provisions. Thus 10 stipulate that the specified number of days for mental illness is the maximum that will be provided in a contract year; another 18 make it the maximum that will be provided within a 12-month period; and three others the maximum that will be provided in a calendar year. Four plans specify that the given number of days is the total that will be provided during the life of the member. The various arrangements are set forth below:

	Plans
All plans	75
Plans providing no benefits	11
Plans requiring specified days since discharge for new admission	28
Zero	1
28	[1] 1
30	1
60–90	17
180	6
365	2
Plans placing limit on days in a specified period	36
Contract year	10
12-month period	18
6 months	1
Calendar year	3
Life	4

[1] 28 days for the subscriber, 90 days for family members.

Benefits for mental illness in private mental hospitals.—Benefits for the care of mental illness in private mental hospitals are markedly less generous than for care of mental illness in general hospitals. About one-third of the plans provide no benefits in such hospitals and 39 provide only 30, 31 or fewer days of care. Only 10 plans provide 45 or more days of care in such hospitals and one of these limits the benefits to $12.50 a week. Details are shown below:

Days	Plans
All plans	75
Not specified	2
None	23
10–19	3
20–21	3
30–31	33
45–70	[1] 5
120	5
Other [2]	1

[1] One of these provides benefits of $12.50 per week for up to 56 days per confinement.
[2] Provides up to $140 in mental hospitals per year.

The basis for determining benefits in private mental hospitals is summarized below:

	Plans
All plans	75
Plans providing no benefits	[1] 23
Plans requiring specified days since discharge for any new admission	23
28	1
60	2
90	10
180	8
365	2
Plans placing limit on days within a given period	29
In contract year	7
In a 12-month period	12
In calendar year	4
During life	4
During 6 months	1
Other [2]	1

[1] Includes 2 that provide benefits only in member hospitals and no private mental hospital as such.
[2] Provides benefits up to $140 a year.

Twenty-three plans stipulate that any admission within a specified number of days of discharge from a mental hospital shall be considered as a continuation of the former period of care. The specified number of days is 60 in two plans, 90 days in 10 plans, 180 days in eight plans, and 365 days in two plans. Twenty-eight limit the number of benefit days within a specified period; seven stipulate that the specified number of days will be the maximum in a contract year; 12 the maximum in a 12-month period; four the maximum in a calendar year; and four the maximum during life.

Benefits in public mental hospitals.—Benefit days in public mental hospitals are still more restricted, as shown below:

Days	Plans
All plans	75
Not specified	2
No benefits	[1] 39
10 days	2
20 days	2
30–31 days	22
45–70 days	[2] 5
120 days	2
Other [3]	1

[1] Includes 2 that provide benefits only in member hospitals.
[2] Includes 1 plan that provides benefits of $12.50 per week for up to 8 weeks.
[3] Provides benefits up to $140 per contract year.

Several of the plans classified as providing no benefits do not have a specific exclusion against care in public mental hospitals, but specify that no benefits will be provided in a hospital owned by the State government. In almost all States such a provision rules out care in public mental hospitals.

A majority of the plans that provide benefits in public mental hospitals stipulate that the specified number of days of benefits is the maximum that will be provided in the period of a year—variously defined as a contract year, 12-month period, or calendar year. Three plans, one providing 10 days and two providing 30 days, specify that this is the maximum during the member's life.

The restriction on benefits provided in private and public mental hospitals probably reflects the influence of a number of factors: First, the plans were largely started by, and have throughout largely been controlled by, persons connected with general hospitals; prime attention has been given to general hospitals and general illness. Second, plans lacked assurance of the quality of care in some private mental hospitals and hence hesitated to provide care in such hospitals. Third, care in public mental hospitals has had some of the attributes of a free public service. In many States little effort is made to assess the ability of patients to pay and most patients pay little or nothing. The plans have been loath to pay for such care when in

many cases the members could obtain it free of charge. There is a clear need in this area for coordination of private and public effort and responsibility.

Benefits for Care of Tuberculosis

In general, Blue Cross plans provide only restricted benefits for tuberculosis, the situation being much the same as for mental illness. Only 15 plans provide in general hospitals the same benefits for care of tuberculosis as for general illness. One of these plans provides these benefits only in cases requiring surgery. Twenty plans provide no benefits for tuberculosis in general hospitals, nine provide 21 or fewer days of care, 29 provide 30 to 31 days, and only 10 provide 120 or more days of care. Details are shown below:

Days	*Plans*
All plans	75
Not specified	[1] 2
Zero days	20
Under 20	4
20–21	[2] 5
30–31	29
60–70	[2] 4
100	1
120 or 125	9
180	1

[1] 1 of these provides benefits only in surgical cases.
[2] 1 of these provides additional days of partial benefits.

The provisions of the plans regarding determination of a new admission for tuberculosis or limitations on days in any given period are much the same as for mental illness and are summarized below:

	Plans
All plans	75
Plans providing no benefits	20
Plans requiring specified days since discharge for new admission	29
Not specified	1
Zero	1
28	1
60–90	17
180	7
365	2
Plans placing limit on days in specified period	26
Contract year	6
Calendar year	2
12-month period	15
Life	3

Benefits for the care of tuberculosis in private tuberculosis hospitals are much more restricted than in general hospitals and benefits in public tuberculosis hospitals are still further restricted. In some States the latter restrictions are of no consequence since the State provides free care in public tuberculosis hospitals to all residents irrespective of income. The benefit provisions of the plans are summarized below:

Days	*Plans*	
	In private tuberculosis hospitals	*In public tuberculosis hospitals*
All plans	75	75
Zero benefits	33	45
Not specified	2	1
Under 20	1	1
20–21	4	2
30–31	24	18
45–70	[1] 4	[1] 4
100	1	
120	5	2
180	1	1
Other [2]	1	[2] 1

[1] 1 provides $12.50 per week for up to 8 weeks.
[2] Provides benefits up to $140 per year.

The basis for determining benefits in tuberculosis hospitals is shown below:

	Private hospitals	*Public hospitals*
All plans	75	75
Plans providing no benefits	33	45
Plans requiring specified days since discharge for new admission	22	13
28	1	1
60–90	10	4
180	8	6
365	2	1
Other [1]	1	1
Plans placing limit on days within a specified period	20	17
Calendar year	3	1
Contract year	4	5
12-month period	10	8
Life	3	3

[1] Benefits limited to $140 per year.

As in the case of public mental hospitals, frequently the exclusion of care in public tuberculosis hospitals results from a general exclusion of all care in hospitals operated by the Federal Government or a State government.

Inpatient Hospital Services Covered

In considering the inpatient hospital services covered by Blue Cross plans it should be borne in mind that conceptions differ from one area to another and from one hospital to another as to those services that are "hospital" services and may, therefore, be appropriately provided and billed for by hospitals, and those services that are "professional" or "medical" services and which may,

therefore, be provided and billed for by physicians. The latter services in hospitals would ordinarily be covered by the companion Blue Shield plan. The situation is rendered more complex by the fact that although certain services, notably pathological examinations, laboratory examinations, X-ray diagnostic examinations, X-ray therapy, radium therapy, anesthesia, and physical therapy services, may be considered as professional services because they are rendered by physicians or provided under the direction of physicians, they nevertheless in certain hospitals are rendered by physicians who are members of the hospital's paid staff, in which case the hospital customarily bills for the services. In still other hospitals, these services are rendered by physicians who are not salaried employees of the hospital but nevertheless provide their services under contractual arrangements with the hospital and frequently receive their remuneration in the form of a percentage of the proceeds of the department. In such case, while the hospital may not furnish these services, it does bill for them, so that the public tends to consider these services as hospital services.

Blue Cross and Blue Shield plans have adapted themselves to these varying situations and conceptions, with Blue Cross generally covering services furnished or billed for by the hospital and Blue Shield covering services that are furnished by and customarily billed for by physicians. For example, in some areas both the Blue Cross plans and the Blue Shield plans cover X-ray examinations in the hospitals. In this situation, Blue Cross covers X-ray examinations in hospitals where they are furnished or billed for by the hospital and Blue Shield covers these same services in hospitals where they are furnished and billed for by physicians. Frequently, to simplify the matter, these services may be paid for initially by Blue Cross, which is later reimbursed by Blue Shield, in conformity with the desires of the hospitals and medical profession of the area.

In any case, the fact that certain services are not covered by Blue Cross does not mean that the subscriber is not covered against the service. Usually the coverage is provided under his Blue Shield contract. (In most areas except the west coast virtually all subscribers to Blue Cross are also subscribers to Blue Shield.) To the subscriber, it makes no difference as long as the services are covered by one plan or another.

The great majority of Blue Cross plans list in their contracts the hospital services provided to subscribers. Eight plans,[5] instead of listing the particular services covered, simply indicate that they cover all services customarily provided by member hospitals. Some of these list a few specific covered services, such as operating room, special diets or drugs, and then state that all other hospital services customarily furnished by member hospitals are also covered. A few plans, as will be indicated later, cover some hospital services only in part.

Because of differing conceptions as to whether given services are "hospital" or "professional" services, the semantics of the contracts vary considerably. Some contracts list certain services as covered. Other contracts list certain services as covered and other services as covered if customarily furnished by the hospital. Some specify certain services as covered if furnished and billed for by the hospital. Still others specify that certain services are covered only if provided by hospital employees. One plan states that it covers the hospital components of certain services.

Table 2–3 shows the hospital services covered by the various plans. All plans but one cover in full the use of operating room and the provision of special diets. The exception is the Memphis plan, which under its most widely held contract covers 80 percent of hospital charges for each hospital service. All plans, with the exception of the Memphis and the Maine plans, cover in full the cost of prescribed drugs. Generally the drugs covered are those listed in the U.S. Pharmacopeia, the National Formulary, and New and Non-Official Remedies. The Maine plan covers drugs, oxygen, and materials used in dressings and casts only up to a maximum of $100. The Syracuse and Utica, New York plans cover all drugs listed in the U.S. Pharmacopeia and National Formulary and cover other drugs up to a maximum of $10 per contract year.

All plans with the exception of the Maine and Memphis plans cover in full the cost of dressings and casts.

Laboratory services are covered in full and without qualification by 54 of the 75 plans and two

[5] Rochester, N. Y.; Philadelphia, Pa.; Wilkes-Barre, Pa.; Youngstown, Ohio; Wisconsin; Minnesota; Memphis, Tenn.; and New Mexico.

other plans (Maine and Memphis) unqualifiedly cover part of the cost. The Maine plan covers 50 percent of the first $70 of charges for laboratory services and provides full coverage of charges in excess of $70. Ten plans cover those laboratory services customarily provided and billed for by the hospital; four others do the same but with the qualification that the services must be performed by employees of the hospital.[6] One plan covers only the "hospital component" of laboratory services. One plan covers laboratory examinations except for section and pathology examinations. Three plans do not cover laboratory examinations, such coverage being provided by the companion Blue Shield plan.

Basal metabolism tests are covered without qualification by 48 plans (but only for 50 percent of the first $70 of expense for this and other diagnostic examinations by the Maine plan and only up to 80 percent of charges by the Memphis plan). Fifteen plans cover these services when customarily furnished by the hospital; some of these plans also specify that the service must be performed by a hospital employee. Ten plans do not cover this service.

Electrocardiograms are covered without qualification by 45 plans, covered if customarily furnished by the hospital (and in some cases only when performed by hospital employees) by 17 plans, covered in part by two plans, and not covered by 11 plans.

Electroencephalograms are covered without qualification by 22 plans, covered by an additional 14 plans when furnished by the hospital, covered by one plan (Memphis) up to 80 percent of charges, and not covered by 38 plans.

Thirty-nine plans cover X-ray examinations without qualification. An additional 16 plans cover these examinations only when they are customarily provided by the hospital, some of the plans also specifying that the service must be provided by hospital employees. Six plans cover only part of the charges for X-ray examinations (in some of these plans the remaining charges would be covered by Blue Shield), one plan covers X-ray examinations only in accident cases, and 12 do not cover this service.

X-ray therapy is covered in full and without qualification by 16 plans,[7] is covered when customarily provided and billed for by the hospital (and in some cases only when performed by hospital employees) by an additional 12 plans, is covered up to 80 percent of charges by one plan (Memphis), and is not covered by 46 plans.

Radium therapy is not covered by 57 plans, covered in full and without qualification by six plans, covered when customarily provided and billed for by the hospital (and in some cases when provided by hospital employees) by 10 plans, covered only for malignancies except those of the skin by one plan, and covered up to 80 percent of charges by another.

Physical therapy services in hospitals are generally provided by technicians or therapists working under the supervision of a physician specializing in physical medicine. The service is covered in full and without qualification by 48 plans. Four plans cover hospital charges for the use of equipment. Thirteen plans cover the charges for this service when customarily provided by the hospital and/or a hospital employee or as regards the hospital component of the service. The Memphis plan covers 80 percent of the charges for this service when rendered by a hospital employee. An additional plan (Montana) covers the service "if administered by or under the supervision of a registered physical therapist in the employ of the hospital." Eight plans do not cover the service.

Charges for anesthesia service by physicians are covered, as will be shown in the next chapter, by all or virtually all Blue Shield plans. The hospital's charges for the use of anesthesia supplies and equipment and for anesthesia service when performed by a nurse anesthetist employed by the hospital are generally covered under Blue Cross plans. The wording of plan contracts was not fully clear in some cases. It appears that seven plans do not cover anesthesia charges at all (presumably the charges for materials and use of equipment are included in the physician's charge, which is covered under Blue Shield). Thirty-eight plans cover charges for this service as regards supplies, use of equipment, and administration by hospital em-

[6] One of these plans makes the further provision that the service must be provided by a full-time employee of the hospital "who is not compensated by percentage of fees or other commission arrangement."

[7] One of these covers X-ray therapy only for treatment of proven malignancies, except those of the skin.

ployees [8] Another eight plans cover charges only for supplies and use of equipment. Three plans cover charges for "administration of anesthesia" (one of these covers only 80 percent of charges and specifies that the service must be one provided by a hospital employee), 13 plans cover anesthesia when rendered as a hospital service, and five plans cover anesthesia and administration thereof without further specification.

Administration of oxygen is covered by all plans. Administration of blood is covered without qualification by 51 plans, covered for the hospital component by one, covered as a hospital service up to 80 percent by one, and covered up to $10 by another. It is not covered by 12 Blue Cross plans.

Outpatient Services

Accidents and medical emergencies.—All Blue Cross plans except one provide outpatient benefits for accident cases (see table 2–4). The exception is the New Hampshire-Vermont plan, which under its Blue Shield contract provides coverage of physician service in the office and outpatient department. One plan (Wyoming) provides benefits not only for accidents, but for medical emergencies as well.

Twenty-three plans limit the benefits to the initial treatment of the accidental injury. One plan covers "intentional injuries," i.e., attempts at suicide. Whether other plans in practice would interpret "accidents" broadly enough to include attempts at suicide is not certain.

Almost all of the plans require that the outpatient visit must be within a certain period of time following the accident. In 30 plans, the time limit is 24 hours; in 24 plans, 72 hours; and in 11 plans, 48 hours. Three plans have no such time limit and five will provide benefits within 7 to 14 days of the accident. Details are shown below:

Time limit (hours or days)	*Plans*
All plans	75
No benefit	1
12 hours	1
24 hours	30
48 hours	11
72 hours	24
7 days	3
8 days	1
14 days	1
No time limit specified	3

All of the plans providing outpatient benefits for accident cases or medical emergencies provide all of the hospital services. However, 11 impose dollar limitations on the amount of hospital charges covered. Three plans put the limit at $7 or $7.25, one at $10, two at $20, two at $15, one at $25, and one at $30. Another (Roanoke) stipulates that it will not pay more than $5 for materials and supplies or more than $10 for X-ray examinations. The Massachusetts plan will pay no more than $50 for diagnostic X-rays in accident cases. The Memphis plan pays 80 percent of hospital charges for outpatient services, the same as for inpatient services.

Minor surgery.—The great majority of the plans, 65 out of 75, provide outpatient benefits for minor surgery, i.e., use of operating room and other services required for surgery performed on an outpatient basis. Most plans cover this service because otherwise the patient would be hospitalized and the end cost to the plan would be larger. Most plans cover all needed services, the exceptions being one that covers use of operating room only, two that cover use of the operating room up to a dollar limit, and four that put dollar limits on the benefits for this service.

Other outpatient services.—Some 17 plans provide other outpatient services, mainly X-ray and/or laboratory examinations, X-ray therapy, radiation therapy, etc.

Benefits in Noncontracting Hospitals

Benefits in noncontracting hospitals are of three types: those in such hospitals within the plan area, those in such hospitals outside the plan area, and those in member hospitals of other Blue Cross plans. The latter are by far the most important.

Generally, the plans provide appreciably smaller benefits in noncontracting hospitals in the plan

[8] One of these covers such charges only up to 80 percent and another only up to $15.

area than in contracting hospitals. This is so for a variety of reasons. A hospital within the plan's area may choose not to be a contracting hopsital because it does not wish to accept the plan's basis of remuneration or to assume the obligations of a contracting hospital. The plan, in effect, penalizes such a hospital and the subscribers who use it by providing smaller benefits than otherwise would be the case. If the plan did not do so, fewer hospitals would become contracting ones. Some hospitals are nonparticipating because they have failed to meet the standards set by the plan for participation. The plan, for one reason or another, is not willing to deny all benefits for services performed by nonparticipating hospitals, but it deems it appropriate to provide lower benefits than those payable in contracting hospitals. In some cases, the plan may offer participation only to general hospitals. In this case, private or public mental hospitals, for example, are perforce nonparticipating hospitals.

The most common benefit in noncontracting hospitals is a flat allowance for each day of care, e.g., $10, $15, or $20. Some plans provide a larger allowance for the first day of care, smaller allowances for the second and third day, and a still smaller allowance for each day thereafter. Nineteen plans provide this type of allowance.

The next most common type of benefit is for the plan to pay a certain percentage—commonly 75, 80, or 85 percent—of the hospital's charges for both a semiprivate room and ancillary services; 14 plans do this. Some plans provide a flat allowance per day for the room and a flat allowance against all charges for the ancillary services—for example, $15 a day for the room and up to $150 for the ancillary charges. Other plans provide a flat room allowance and pay a specified percentage of the charges for the ancillary services. Some 20 plans have one or the other of these two arrangements. Three plans provide regular benefits and a few no benefits whatever. The remainder have other combinations of the arrangements cited.

Most plans provide the same benefits in noncontracting hospitals outside the plan area as in noncontracting hospitals located within the area. A few plans provide full benefits, presumably on the reasoning that a noncontracting hospital outside its area does not have the choice of becoming one of its contracting hospitals.

From the standpoint of member usage, the benefits that a plan provides in member hospitals of other Blue Cross plans are of considerably more moment than benefits in noncontracting hospitals within or outside the plan's area.

All Blue Cross plans participate in what is known as the Interplan Service Benefit Bank. This, as described by the Blue Cross Association, "is a mechanism through which each Blue Cross plan . . . may authorize hospital care benefits for its subscribers when they are admitted as inpatients to contracting hospitals of another Blue Cross plan. The Bank operated by the Blue Cross Association serves as coordinator between the Home Plan in which the patient is enrolled as a member and the Host Plan serving the area in which the hospital is located in the provision of and payment for covered services.

"The amount and kind of care to be provided to a subscriber hospitalized out-of-area is determined by messages exchanged between the Host and Home Plan using the telecommunication system of the Blue Cross Association. However, approval by the Home Plan is specifically limited to the: (1) confirmation of the patient's eligibility for benefits; (2) determination of the number of days during which care may be rendered, according to the benefit days specified in the member certificate and prior utilization; (3) designation of the scope of covered ancillary services as specified in a Host Plan certificate approved for Bank use and (4) exercise of its option to authorize the Host Plan to provide and pay for service benefits in maternity cases if Host Plan certificates provide only an indemnity allowance for maternity care. Except for the above Home Plan prerogatives, the out-of-area patient is treated as though he were a member of the Host Plan.

"The Bank reimburses Host Plans the exact amount of their payments to hospitals and, in turn, Home Plans reimburse the Bank in accordance with the formula which is designed to produce adequate funds to cover both payments to Host Plans and operating cost . . ." [9]

From the analysis of the plan certificates, the plans appear to be distributed as follows with respect to the benefits provided member hospitals of other Blue Cross plans.

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[9] *Blue Cross Manual* (as of early 1969), section on Inter-Plan Service Benefit Bank, p. 264.

Type of benefit	*Plan*
All plans	75
Service benefits of Host Plan as designated by Home Plan	27
Service benefits of Home Plan	17
Service benefits of Host Plan and reimbursement of the member to the extent such benefits are less than the allowance against like charges in a participating hospital	8
Services of Host Plan with limitations of Home Plan	4
All services of Home Plan to the extent rendered and billed for by member hospitals of Host Plan	3
Service benefits of Host Plan or benefits of Home Plan in noncontracting hospitals, whichever is more favorable to the subscriber	6
Not specified	8
Other	2

Some of these options do not jibe with the specifications of what Home Plans may specify in the above description of the Interplan Service Benefit Bank's functions. Nevertheless, this is what emerges from a reading of the contract. It is obvious that the matter is a complicated one. It is made so by the differences in the hospital services that the various plans cover and much of these differences are, in turn, traceable to differences in what are considered to be hospital services or medical services in the various plan areas.

Maternity Benefits

All of the plans under their most widely held contracts provide maternity benefits subject to a waiting period of 8, 9, or 10 months (see table 2–5).[10] Twenty-nine plans have no limits either on number of days of care for maternity cases or dollar limits on benefits; 22 have limits on maternity stays; and another 22 have dollar limits; with the limits on days or dollars not being specified in the contracts of two plans. Limits on days of care for normal maternity stays are as follows:

Days	*Plans*
All plans	22
6 days	1
7 days	3
8 days	1
10 days	16
14 days	1

The dollar allowances for maternity benefits of the 22 plans with such allowances are shown below. More than half of the plans with dollar allowances allow $80 or less, amounts that will not go far in meeting the cost of a maternity confinement at today's hospital charges.

	Plan
Total	22
$50	3
$75	3
$80	7
$100	4
$120 or $125	2
$150 or $200	2
Not specified	1

The maternity waiting period is 9 months in 58 plans. It is 7 months in one other plan, 8 months in six plans, 10 months in nine plans, and not specified in the contract of one plan.

Routine nursery care of the newborn child is covered in 64 plans, but not covered in 11 others. The 64 plans that cover nursery care of the newborn include some that provide low dollar allowances for maternity benefits. In some of these plans the coverage of nursery care is token only since the dollar allowance would fall far short of paying for the mother's care.

Coverage of Certain Special Conditions

This section deals with certain conditions or types of illnesses that are, or in the past have been, frequently excluded from Blue Cross coverage.

Hospitalization for alcoholism is covered, without any limit on days of care, by 33 plans. It is covered for up to a specified maximum number of days by 19 plans, of which 11 limit days of care to 30, three to 14 or 15 days, three to 20 or 21 days, one to 25, and one to 70 days. (Generally the specified days apply to a 1-year period.) Twenty-two plans completely exclude coverage for this condition.

The situation with respect to coverage of hospitalization for drug addiction is virtually the same. All except three plans have the same provisions with regard to both conditions. These three plans cover hospitalization for drug addiction, but restrict hospitalization for alcoholism to a specified number of days.

Self inflicted injuries, i.e., those resulting from attempts at suicide, are covered by 71 plans; they are not covered by four.

[10] It should be understood that all or virtually all plans will waive the waiting period for maternity benefits if a large group or national account so desires.

Venereal disease is covered by 69 plans and not covered by six.

Hospitalization for care of congenital malformations is covered without restriction by 62 plans, covered after a waiting period—generally 9 or 12 months—by eight plans, and not covered by five. Hospitalization for correction of these conditions would also be subject to a plan's limitations on coverage of pre-existing conditions, which will be discussed later. Quarantinable diseases are covered by 72 plans and not covered by three.

Twenty-six plans under their most widely held contract cover pre-existing conditions (i.e., conditions that the subscriber was aware of prior to enrollment) without a waiting period. Forty-five cover them after a waiting period of from 6 to 24 months and four do not cover these conditions at all. The waiting periods (months of enrollment before the plan will provide benefits) for the plans that have them are as follows:

Waiting period	*Plans*
All plans	45
6 months	4
7 months	1
9 months	9
10 months	2
11 months	10
12 months	17
24 months	2

All plans will waive any restrictions on coverage of pre-existing conditions for large groups or national accounts.

Hospital care for sterilization operations is covered by 72 plans; it is not covered by two and covered with a 9-month waiting period by 1 plan.

Cosmetic surgery is not covered by 32 plans, but is covered by 43. Some of the plans listed as not covering cosmetic surgery cover it in case of accidental injuries.

Hospitalization for tonsil and adenoid operations is covered without a waiting period by 41 plans and is covered after a waiting period by 34 plans. Of these, 18 plans have a waiting period of 6 months, nine of 9 months, and seven of 10, 11, or 12 months.

Admissions for diagnostic studies are not covered by 62 plans. They are covered without qualification by 11 plans, and covered for specified defined diagnostic procedures by two plans.[11]

Nine plans have waiting periods for hospital care for other specified conditions or procedures. Thus the New Hampshire-Vermont plan has a waiting period of 9 months for care of hernia, varicose veins, hemorrhoids and any condition involving the female genital system. The South Carolina plan has a waiting period of 6 months for hemorrhoidectomies and hernia, except strangulated. The Baton Rouge, La. plan has a waiting period of 12 months for surgery or treatment of the reproductive organs, hemorrhoids, or hernias. The Colorado plan has a waiting period of 11 months before benefits for gall bladder disease and ulcers of the stomach or duodenum become payable.

Benefits for Nursing Home Care and Visiting Nurse Service

Benefits in nursing homes are provided by three plans (Rochester, N.Y., Minnesota, and Delaware) under their most widely held contracts. The Rochester plan allows the member 2 days of care in an extended care facility or nursing home for each of the 120 days not utilized for hospital confinement. The plan pays 80 percent of nursing-home charges up to $15 a day.

The Minnesota plan provides up to 70 days of care with each such day counting as one-half a day of hospitalization. Benefits are available only if the subscriber was previously confined in a hospital for not less than 3 days for the same condition, and care commenced within 14 days of discharge from the hospital. The plan covers charges for room and board in a room with two or more beds up to $15 a day.

The Delaware plan provides benefits in an extended care facility provided the admission is for the same condition as that for which the subscriber has received care immediately before in an acute hospital, or is for care provided in lieu of admission to an acute hospital. Care is provided for the length of stay that in the judgment of the plan would represent a reasonable term of hospitalization for the condition in question, but not in excess of 120 days per admission, with any subsequent admission within 180 days of discharge being considered as a continuation of the former admission. The plan covers the full cost of care in a partic-

[11] One of these covers for X-rays within a 30-day period of surgery and another covers for certain defined diagnostic procedures.

ipating facility, and up to $10 per day in a nonparticipating facility.

Seven plans (Rochester, N.Y., Allentown, Harrisburg, Philadelphia, Pittsburgh, and Wilkes-Barre, Pa., and Delaware) provide visiting nurse benefits.

The Rochester plan, which provides the benefits through a contracting organization, provides full coverage of visiting nurse and other home health services for up to 200 home care visits of all types per year. However, after the first 100 home care visits, plan coverage for the visiting health aide (homemaker) is reduced to 50 percent of the cost of this service.

The first four named Pennsylvania plans provide the coverage only for subscribers who are aged 65 and over. After being discharged from the hospital the subscriber is eligible for visting nurse services, with each visit counting as one-half a day of hospitalization. Benefits are limited to 20 visits with respect to each period of hospitalization. The Pittsburgh plan covers visiting nurse service immediately after hospitalization—each visit counts as a quarter of a day of hospitalization, and these visits are limited to 30 per period of hospitalization.

The Delaware plan provides home care benefits when hospital benefit days are available, with each 2 days of home care benefits counted as 1 day of hospitalization.

Age Limits for Dependent Children

Table 2–6 shows the provisions of coverage for newborn infants, the age at which unmarried dependent children cease to be eligible for care under their parent's certificate, the provisions with respect to unmarried children over this age who are incapable of self support, and the plans that have coordination-of-benefit provisions.

Of the 75 plans, 65 cover newborn infants from birth. Ten plans cover such infants only after a certain interval—14 or 15 days in eight plans, 11 days in one plan, and 30 days in another. Three other plans provide coverage under certain qualifying conditions and are here included among those providing coverage from birth.

All plans discontinue coverage of unmarried dependent children at age 19. However, six plans continue coverage for an additional number of years if the child is enrolled in a college or university. Two plans cover the child up to age 23, one plan up to age 24, and three plans continue coverage regardless of age.

Nineteen plans continue coverage of unmarried dependent children beyond age 19 if the child is incapable of self support by reason of physical or mental disability. Fifteen plans continue coverage for such a child regardless of age, two plans continue such coverage up to age 23, and two plans up to age 25.

Coordination of Benefit Provisions

Provisions for coordination of benefits among insurers, when a covered person is covered by two or more insurers, so as to define the responsibility of each insurer and prevent the insured from recovering more than the total charges for the services received, are of growing importance. Provisions relating to coordination of benefits are common under group health insurance policies of insurance companies. This concept appears thus far to have made relatively little headway among Blue Cross plans. At any rate, only 10 of the 75 plans have a "coordination of benefits" provision in the contracts here examined. It is understood, however, that most plans will "coordinate" for large accounts if the purchaser desires this service.

Summary

A joint summary of Blue Cross-Blue Shield benefit provisions is provided at the end of the chapter on Blue Shield plans, on page 43 of this report.

TABLE 2-1.—Blue Cross plans: Subscription rates, room accommodations or allowances, deductible and co-pay provisions, and allowances for better accommodations

Region, State, and plan	Total enrollment, December 31, 1967 (in thousands)	Monthly subscription rate			Room accommodations		Deductible (amount per admission)	Co-pay (amount per day)	Allowance for better accommodations	
		1 person	2 persons	Family	Specified accommodations	Room allowance			Room	Services
New England:										
Maine	385	NA	NA	NA		[1] $9–$24				
New Hampshire-Vermont	400	NA	NA	NA		8– 30				[2].
Massachusetts	3,145	NA	NA	NA		12– 15				[2].
Rhode Island	702	NA	NA	NA	SP or	14– 28				
Connecticut	1,491	$3.70		$8.70		15				
Middle Atlantic:										
New York:										
Albany	425	8.24		16.60	SP				SPch	Full.
Buffalo	889	5.36		11.82	SP				SPch	Full.
Jamestown	56	NA	NA	NA	SP				SPch	Full.
New York City	7,605	4.84		11.32	SP				SPch [3]	Full. [3]
Rochester	745	5.24		10.48	SP				SPch	Full.
Syracuse	432	6.40		12.80	SP				SPch	Full.
Utica	262	5.30	[4] $5.30	10.60	SP				SPch	Full.
Watertown	31	4.60		11.00	SP				SPch	Full.
New Jersey	3,046	5.41	[4] 7.92	13.98	SP				SPch	SPch.
Pennsylvania:										
Allentown	369	3.60		10.55	SP				Up to $9	Full.
Harrisburg	828	NA	NA	NA	SP			$2.50	SPch	SPch.
Philadelphia	2,192	5.30	[4] 10.40	15.75	SP			20 days 5.00 [5] 15 days.	80% up to 15 days.	Full.
Pittsburgh	2,128	NA	NA	NA	W				85% of Wch	Full.
Wilkes-Barre	438	NA	NA	NA	SP			5.00 [5] 15 days.	SPch	Full.
East North Central:										
Ohio:										
Canton	231	5.75		12.50	SP				SPch	Full.
Cincinnati	1,541	5.75		13.70	SP				SPch	Full.
Cleveland	1,686	[6] 8.60		17.20	SP or W				SPch or Wch	Full.
Columbus	586	5.20		13.43	SP					
Lima	133	5.23		13.07	SP				SPch	Full.
Toledo	548	NA	NA	NA	SP or W				SPch or Wch.	Full.
Youngstown	325	8.25		15.80	SP				SPch	Full.
Indiana	1,822	[7] 6.49		[7] 17.20	SP				SPch	Full.
Illinois:										
Chicago	2,674	8.14		21.22	SP				$10	Full.
Rockford	151	NA	NA	NA	SP or	$10–30			[8]	Full.
Michigan	4,587	NA	NA	NA	SP or W				SPch or Wch	Full.
Wisconsin	1,185	NA	NA	NA	SP				SPch	Full.
West North Central:										
Minnesota	810	8.35		21.15	SP				SPch	Full.
Iowa:										
Des Moines	736	6.30		11.90	SP				SPch	Full.
Sioux City	190	NA	NA	NA	SP				SPch	Full.
Missouri:										
Kansas City	447	NA	NA	NA	SP				SPch	Full.
St. Louis	1,128	4.30		10.35	SP				$10	Full.
North Dakota	235	6.20		14.55	SP		$25		SPch	Full.
Nebraska	272	NA	NA	NA	SP or	8–20			$8 to $20 [9]	Full.
Kansas	663	7.68		16.18	SP				SPch	Full.
South Atlantic:										
Delaware	359	NA	NA	NA	SP				SPch	Full.
Maryland	1,188	NA	NA	NA	SP				SPch	Full.
District of Columbia	1,204	4.10		11.42	SP				SPch	Full.

See codes and footnotes at end of table.

TABLE 2-1.—Blue Cross plans: Subscription rates, room accommodations or allowances, deductible and co-pay provisions, and allowances for better accommodations—Continued

Region, State, and plan	Total enrollment, December 31, 1967 (in thousands)	Monthly subscription rate			Room accommodations		Deductible (amount per admission)	Co-pay (amount per day)	Allowance for better accommodations	
		1 person	2 persons	Family	Specified accommodations	Room allowance			Room	Services
South Atlantic—Con.										
Virginia:										
Richmond	755	NA	NA	NA	SP				[16]	[16]
Roanoke	272	$4.50	$9.00	$10.80	SP				SPch	Full.
West Virginia:										
Bluefield	23	NA	NA	NA	W				Wch	Full.
Charleston	168	NA	NA	NA		X				
Parkersburg	41	5.50		13.40	SP				$12	Full.
Wheeling	108	5.45		11.85		$12				
North Carolina:										
Chapel Hill [11]	771	NA	NA	NA		[12] X				
Durham [11]	533	NA	NA	NA		5–20				
South Carolina	338	NA	NA	NA	SP		[13]		Spch	Full.
Georgia:										
Atlanta	341	NA	NA	NA	SP				Spch	Full.
Columbus	331	NA	NA	NA		X	[14] 30–50			
Florida	1,067	2.80		8.40		7				
East South Central:										
Kentucky	1,021	3.25		11.05	SP				$10	Full.
Tennessee:										
Chattanooga	1,002	2.95		8.85		8				
Memphis	137	NA		NA		X		[15]	[15]	[15]
Alabama	842	[16] 4.55		14.50	SP		25		SPch	Full.
Mississippi	460	[17] 3.35	[17] 8.37	[17] 9.86		10				
West South Central:										
Arkansas	325	NA		NA		X	X			
Louisiana:										
Baton Rouge	440	3.64		10.21		8	25			
New Orleans	304	NA		NA		X	[18]			
Oklahoma	550	5.30		12.40	SP		25		SPch	Full.
Texas	1,675	NA		NA		X	[19]			
Mountain:										
Montana	42	[17] 8.10		15.51	SP				SPch	Full.
Idaho	106	NA		NA		X				
Wyoming	85	4.85		9.70	SP				SPch	Full.
Colorado	757	[20] 9.75		[20] 19.50	SP				SPch	Full.
New Mexico	113	NA		NA	SP or	10–22	[21]		SPch or RA	Full.
Arizona	241	NA		NA	SP or	20–40			SPch or RA	Full.
Utah	291	[16] 3.68	11.13	11.95	SP				SPch	Full.
Pacific:										
Washington	339	[16] 4.59	10.62	12.06	SP up to	22			SPch up to $22	Full.
Oregon	382	[16] 3.35	8.70	9.65	W up to	22			Wch up to $22	Full.
California:										
Los Angeles	1,632	[16] 6.60	16.70	17.50	W				Wch	Full.
Oakland	1,207	[16] 6.17	16.20	16.20	W				Wch	Full.

See codes and footnotes on next page.

TABLE 2–1.—Blue Cross plans: Subscription rates, room accommodations or allowances, deductible and co-pay provisions, and allowances for better accommodations—Continued

X Yes.
NA Rate not available because it is not shown in Blue Cross Manual or because there are multiple rates depending on specific accommodations or room allowances provided, deductible, days of benefits, etc.
SP Semiprivate accommodations.
W Ward accommodations.
RA Room allowance specified in contract or on identification card.
SPch Hospital's average or most common charge for semiprivate accommodations.
Wch Hospital's average or most common charge for ward accommodations.

[1] $9 plus variable supplemental allowances.
[2] Never to exceed the rates customarily charged occupants of rooms having more than 1 bed.
[3] During partial benefit days the plan pays 50 percent of semiprivate room charges and 50 percent of charges for other covered services.
[4] Subscriber and minor dependent.
[5] During any 12-month period.
[6] Rates for semiprivate accommodations in the counties of Cuyahoga, Georgia, Lake, Loraine, Medina, Portage, and Summit. Lower rates in other counties in plan's territory. Ward rates in both areas are slightly lower.
[7] For groups of 50 or more; new accounts only.
[8] Benefits specified on identification card. Certificates cover semiprivate room in full with selected private room allowances of $10, $12, $14, $16, $18, or $20, or selected pegged room allowances ranging from $10 to $30.
[9] Up to $16 per day under semiprivate room certificate. Otherwise $8, $11, $14, $16, or $20 per day.
[10] Participant served in private accommodations receives hospital services, but pays directly to the hospital its regular charges for bed, board, and nursing services less $6.00 per day.
[11] The Chapel Hill and Durham plans merged on January 1, 1968.
[12] When room allowance is $8 or $9, participant may occupy ward accommodations at no extra cost; where room allowance is $10 or more, participant may occupy semiprivate accommodations at no extra cost.
[13] There is a deductible for each hospital admission; the amount is shown on subscriber's identification card and not specified in contract.
[14] Contract specifies deductible of either $30 or $50 (indicated on member's enrollment card).
[15] Plan pays 80 percent of hospital charges for services.
[16] Rates for men; higher rates for women.
[17] Rates for groups of 25 or more; higher rates for smaller groups.
[18] Offered with and without deductible of $25.
[19] Certificate is unspecific on many features including deductible, room allowance, days of benefit, etc., all of which are specified on subscriber's identification card.
[20] For low-level use groups; high-level use groups pay more.
[21] Plan has both deductible and nondeductible certificates; the contract does not specify.

TABLE 2–2.—Blue Cross plans: Duration of benefits for general and mental illness and tuberculosis

Region, State, and plan	General illness				Mental illness						Tuberculosis					
							In mental hospitals						In tuberculosis hospitals			
	Full benefits (days)*	Partial benefits		Days required for new admission	In general hospitals		Private		Public		In general hospitals		Private		Public	
		Days	Percent or amount		Days	Basis	Days	Basis	Days	Basis	Days	Basis	Days	Basis	Days	Basis
New England:																
Maine	21	100	(1)	30	21	A-yr.	21	A-yr.			21	A-yr.	21	A-yr.		
New Hampshire-Vermont	60	60	@50%		[2] 60	A-O					[2] 60	A-O				
Massachusetts	120			90	10	B-life	10	B-life	10	B-life	10	B-life	10	B-life	10	B-life
Rhode Island	120			[3] 90	120	A-90	45	B-cal.[4]	45	B-cal.	120	A-90	45	B-cal.[4]	45	B-cal.
Connecticut	120	[5] 365	[5] $7,500	30	[6] 30	A-180	[6] 30	A-180	[6] 30	A-180	[6] 30	A-180	[6] 30	A-180	[6] 30	A-180
Middle Atlantic:																
New York:																
Albany	70			90	30	B-con.	30	B-con.								
Buffalo	120			90												
Jamestown	(21)			90												
New York City	21	180	@50%	[7] 90	[8] 30	B-yr.					[9] 21	A-90	[9] 21	A-90		
Rochester	120			[10] 60	120	A-60	120	A-60	120	A-60	120	A-60	120	A-60	120	A-60
Syracuse	[11] 70				30	B-con.										
Utica	70	80	$5/day	[10] 90												
Watertown	30	90	$10/day	[12] 90												
New Jersey	[13] 120	[13] 245	$5/day	[12] 90	20	B-con.	20	B-con.	20	B-con.	20	B-con.	20	B-con.	20	B-con.
Pennsylvania:																
Allentown	[14] 30			90	30	B-con.	30	B-con.	30	B-con.	30	B-con.	30	B-con.	30	B-con.
Harrisburg	(70)			90	30	B-life	30	B-life	30	B-life	30	B-life	30	B-life	30	B-life
Philadelphia	[14] 30			90	20	B-con.	20	B-con.	20	B-con.	20	B-con.	20	B-con.	20	B-con.
Pittsburgh	[14] 30			90	30	B-yr.	30	B-yr.	30	B-yr.	[14] 30	A-90				
Wilkes-Barro	[15] 120			90	30	B-con.[16]	30	B-con.[16]	30	B-con.[16]	30	B-con.[16]	30	B-con.[16]	30	B-con.[16]
East North Central:																
Ohio:																
Canton	120			90	120	A-90					120	A-90				
Cincinnati	120			90	120	A-90	120	A-90[17]			120	A-90	120	A-90[17]		
Cleveland	120			90	120	A-90	120	A-90[18]			120	A-90	120	A-90[18]		
Columbus	120			90												
Lima	120			90	12	A-90	12	A-90[17]			120	A-90	120	A-90[17]		
Toledo	70			90	[19] 31	A-90					31	A-90				
Youngstown	120			90												
Indiana	120			90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
Illinois:																
Chicago	120			[12] 90	120	A-90	120	A-90			120	A-90	120	A-90		
Rockford	(120)			90	10	B-con.	10	B-con.	10	B-con.						
Michigan	120			90	30	A-90	30	A-90	30	A-90	30	A-90	30	A-90	30	A-90
Wisconsin	(120)			90	NS	A-90	NS	A-90	NS	A-90						
West North Central:																
Minnesota	70			90	70	A-90	(20)	(20)	(20)	(20)	70	A-90	(20)	(20)	(20)	(20)
Iowa:																
Des Moines	365			90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
Sioux City	120			90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
Missouri:																
Kansas City	120			90	30	B-yr.	30	B-yr.	30	B-yr.	30	B-yr.	30	B-yr.	30	B-yr.
St. Louis	70	180	$3/day	90	14	B-con.	(21)	(21)	(21)	(21)	14	B-con.	(21)	(21)	(21)	(21)
North Dakota	365			90	70	A-180	70	A-180	70	A-180	70	A-180	70	A-180	70	A-180
Nebraska	150			60	30	A-180	30	A-180			30	A-180				
Kansas	120			[10] 90	30	B-con.	30	B-con.[22]	[23] 30	B-con.[24]	120	A-90			[23] 120	B-con.[24]
South Atlantic:																
Delaware	120			90	120	A-90	120	A-90	120	A-90						
Maryland	30			90	30	B-180	30	B-180								
District of Columbia	180			60	30	A-60[25]	30	A-60[25]	30	A-60[25]	180	A-60	0	180 A-60	180	A-60

See codes and footnotes at end of table.

TABLE 2–2.—Blue Cross plans: Duration of benefits for general and mental illness and tuberculosis—Continued

Region, State, and plan	General illness				Mental illness						Tuberculosis					
					In general hospitals		In mental hospitals				In general hospitals		In tuberculosis hospitals			
							Private		Public				Private		Public	
	Full benefits (days)*	Partial benefits: Days	Partial benefits: Percent or amount	Days required for new admission	Days	Basis	Days	Basis	Days	Basis	Days	Basis	Days	Basis	Days	Basis
South Atlantic—Con.																
Virginia:																
Richmond	30			90												
Roanoke	70			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
West Virginia:																
Bluefield	30			90	30	B–cal.	30	B–cal.[26]	(27)	(27)	30	B–cal.	30	B–cal.[26]	(27)	(27)
Charleston	70			90	30	B–cal.	30	B–cal.[26]	(27)	(27)	30	B–cal.	30	B–cal.[26]	(27)	(27)
Parkersburg	70			90	30	B–cal.	30	B–cal.[26]	(27)	(27)						
Wheeling	120			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
North Carolina:																
Chapel Hill	70			90	70	A–90	30	B–yr.	30	B–yr.						
Durham	70			90	30	A–yr.	30	A–yr.	30	A–yr.	30	A–yr.	30	A–yr.	30	A–yr.
South Carolina	(70)			90	15	B–yr.					15	B–yr.				
Georgia:																
Atlanta	(365)			90												
Columbus	(30)			60							(28)					
Florida	31			90	31	B–yr.	31	B–yr.	31	B–yr.	31	B–yr.	31	B–yr.	31	B–yr.
East South Central:																
Kentucky	70			90	31	B–life	31	B–life								
Tennessee:																
Chattanooga	70			90												
Memphis	(120)			90	30	B–life	30	B–life	30	B–life	30	B–life	30	B–life	30	B–life
Alabama	70			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
Mississippi	100			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
West South Central:																
Arkansas	(120)			90	30	B–yr.	(29)		(29)		30	B–yr.	(29)		(29)	
Louisiana:																
Baton Rouge	120			90	30	B–yr.					30	B–yr.				
New Orleans	125			90	125	A–90	30	A–180[30]	(31)	(31)	125	A–90	30	A–180[30]	(31)	(31)
Oklahoma	90			90	30	A–90										
Texas	(360)			90	NS	A–90	NS	A–90	NS	A–90	NS	A–90	NS	A–90	NS	A–90
Mountain:																
Montana	120			[32] 7	30	B–yr.	30	B–yr.			30	B–yr.	30	B–yr.		
Idaho	(70)			90	30	B–yr.					30	B–yr.				
Wyoming	120			90	30	B–con.	(29)		(29)		30	B–con.	(29)		(29)	
Colorado	120			90	30	B–yr.	30	B–yr.			30	B–yr.	30	B–yr.		
New Mexico	(365)			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
Arizona	120			90	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.	30	B–yr.
Utah	[11] 70			30	21	A–30	[33] 56	A–180	[33] 56	A–180	21	A–180	[33] 56	A–180	[33] 56	A–180
Pacific:																
Washington	70			[32] 90	35	B–yr.					14	B–yr.				
Oregon	100			[34] 90	30	A–90	30	A–90			100	A–90	100	A–90		
California:																
Los Angeles	70			[35] 28–90	70	A–28–90	70	A–28–90	70	A–28–90	70	A–28–90	70	A–28–90	70	A–28–90
Oakland	70			[36] 90												

See codes and footnotes on next page.

TABLE 2–2.—Blue Cross plans: Duration of benefits for general and mental illness and tuberculosis—Continued

* In the contracts of 12 plans, days of care were not specified. The Blue Cross Association provided information as to the days of care covered by these plans. These days are shown in parentheses.

A Per admission (with specified period required between admissions).
B During specified benefit period.
cal. Calendar year.
yr. Year (any 12-month period).
con. Contract year.
life Lifetime of member.
NS Not specified.

[1] At regular benefits less $3 a day.
[2] Also 60 partial benefit days at 50 percent per covered services.
[3] However, provided that if either such discharge or subsequent admission within such 90-day period shall be for maternity care or complications of pregnancy or treatment of bodily injury to which either the condition at the respective prior discharge or subsequent admission is unrelated, then such subsequent admission shall be deemed to be a separate period of hospitalization.
[4] Room accommodations plus 90 percent of the hospital's regular charges for other covered services.
[5] Extra benefit days provided only in member general hospitals in Connecticut, with maximum benefits during additional 365 days of $7,500.
[6] Each visit to a hospital's day-care unit or night-care unit shall be charged against the 30-day benefit period as the equivalent of 1 day of hospital care.
[7] During this period subscriber shall neither have been a patient in a hospital nor have received care in a rest, nursing, or convalescent home or institution, or in a sanitarium (even though contract excludes care in such institutions). Also a new period of 21 full benefit days and 180 partial benefit days are allowed if patient is continuously hospitalized for more than 12 months.
[8] Care not available in a separate division of a general hospital where that division has more than 15 percent of total beds or where length of stay is more than 60 days.
[9] For 21 days of a hospital stay which starts with and follows the performance of a surgical operation for the treatment of tuberculosis and limited to the period during which, in the judgment of the plan, postoperative care is necessary because of the surgical procedure performed.
[10] During this period subscriber shall not have been confined in a hospital, a nursing home, or other health care facility.
[11] For each separate and unrelated period of disability.
[12] Applicable if the confinement is for the same or related condition.
[13] 60 days only per certificate year if subscriber is aged 65 through 69, and 30 days if aged 70 or over.
[14] 30 days during first year, 40 days during second year, 50 days during third year, 60 days during fourth year, 70 days during fifth year and each consecutive year for each period of hospitalization.
[15] 120 days for each such period (of hospitalization) during the contract year.
[16] Regular benefits in contracting hospitals; up to $10 per day for 30 days in noncontracting hospitals.
[17] The plan will pay up to $10 for room, board, and general nursing service for 120 days and up to $100 for other covered services.
[18] The plan will pay up to $16 a day for room and board and up to $100 for all other charges for semiprivate subscribers, and up to $15 a day for room and board and up to $90 for other charges for ward subscribers.
[19] 31 days per confinement in the aggregate for the treatment of nervous and mental disorders, alcoholism, and drug addiction.
[20] Care for mental and nervous disorders and tuberculosis only in contracting hospitals which regularly accept such cases, in which case regular benefits apply. One State mental hospital is a member hospital.
[21] Up to $140 for care in mental and tuberculosis hospitals per contract year.
[22] Up to 80 percent of hospital charges.
[23] If operated by the State of Kansas.
[24] Up to $9 per day.
[25] Benefits available only in hospitals accredited by the Joint Commission on Accreditation of Hospitals.
[26] Up to $5 if the hospital is an approved nonparticipating hospital.
[27] Plan excludes hospital services received in any hospital operated or controlled by the United States or any government agency of the United States or any State or political subdivision thereof.
[28] Plan provides benefits only for the surgical treatment of tuberculosis.
[29] Care available in member hospitals only. No mental or TB hospitals are member hospitals.
[30] Room and board allowance only.
[31] Plan excludes benefits for hospitalization in a Federal or governmental institution.
[32] When employee returns to work on a full-time basis, any subsequent admission is considered a new admission.
[33] Plan pays $12.50 per week up to and including 8 full weeks for each confinement.
[34] Any admission for an accident is considered a new admission.
[35] 28 days for the subscriber, 90 days for the family member.
[36] If the subscriber shall have returned to work on a full-time basis following his previous confinement or should readmission be required as a result of accidental injury, such shall constitute a new period of confinement.

TABLE 2–3.—Blue Cross plans: Hospital services covered

Region, State, and plan	All hospital services*	Operating room	Special diets	Drugs	Dressings and casts	Laboratory examinations	Basal metabolism tests	Electrocardiograms	Electroencephalograms	X-ray examinations	X-ray therapy	Radium therapy	Physical therapy	Anesthesia	Oxygen	Administration of blood and plasma
New England:																
Maine		X	X	X [1]	X [1]	X [2]	X [2]	X [2]		X [2]	X	X [3]	X	D	X [1]	
New Hampshire-Vermont		X	X	X	X	X				X [4]				A [5]	X	
Massachusetts		X	X	X	X	X	X	X	X	X	X	X		B [6]	X	
Rhode Island		X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]	X [7]		X [7]	X [7 8]
Connecticut		X	X	X	X	X		X		X	X		X	B	X	
Middle Atlantic:																
New York:																
Albany		X	X	X	X	X	X	X		X			X	A	X	X
Buffalo		X	X	X	X	X								B	X	X
Jamestown		X	X	X	X [9]	X [9]	X [9]			X [9]			X [9]	X [9]	X [9]	X [9]
New York City		X	X	X	X	X	X	X		X			X [10]	A	X	X
Rochester	X [11]	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)
Syracuse		X	X	X [12]	X	X	X						X [10]	A	X	
Utica		X	X	X [13]	X	X							X [10]		X [14]	X
Watertown		X	X	X	X	X	X						X	A	X	
New Jersey		X	X	X	X	X				X			X	D	X	
Pennsylvania:																
Allentown		X	X	X	X	X	X			X			X	A	X	X
Harrisburg		X	X	X	X [9]	X [9]	X [9]	X [9]		X [9]			X [10]	D	X	X
Philadelphia	X [15]	X	X	X	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	X	A	X	X
Pittsburgh		X	X	X	X	X	X	X		X			X	B	X	X
Wilkes-Barre	X [15]	X	X	X	X	X	X	X		X			X	A	X	X
East North Central:																
Ohio:																
Canton		X	X	X	X	X	X			X			X	B	X	
Cincinnati		X	X	X	X	X	X	X		X	X	X	X	A	X	X
Cleveland		X	X	X	X	X	X	X		X			X	A	X	X
Columbus		X	X	X	X	X	X	X		X			X	A	X	X
Lima		X	X	X	X	X	X	X		X	X	X	X	A	X	X
Toledo		X	X	X	X	X	X	X		X			X	B	X	X
Youngstown	X [16]	X	(16)	X	X	(16)	(16)	(16)	(16)	(16)	(16)	(16)	(16)	A	(16)	(16)
Indiana		X	X	X	X	X	X	X		X			X	A	X	X
Illinois:																
Chicago	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	D	X [9]	
Rockford		X	X	X	X	X	X						X		X	X
Michigan		X	X	X	X	X						X	X	A	X	
Wisconsin	X [17]	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(18)	(18)	(17)	D	(17)	(17)
West North Central:																
Minnesota	X [19]	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)
Iowa:																
Des Moines		X	X	X	X	(20)	X	X	X	(20)	(20)		X	A	X	X
Sioux City		X	X	X	X		X	X	X				X	A	X	X
Missouri:																
Kansas City		X	X	X	X	X	X	X	X	X			X	A	X	X
St. Louis		X	X	X	X	X									X	X
North Dakota		X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X [9]	X	X [9]	X [9]	X [9]	X [9]	X [9]
Nebraska		X	X	X									X	A [21]	X	X
Kansas		X	X	X	X	X	X	X	X	X [22]	X	X	X	A [23]	X	X
South Atlantic:																
Delaware		X	X	X	X					80% [24]				80%C	X	X
Maryland		X	X	X	X	X [25]	X [25]	X [25]	X	X [25]	X [25]	X	A	X	X	
District of Columbia		X	X	X	X								X	B	X	X

See codes and footnotes at end of table.

TABLE 2-3.—Blue Cross plans: Hospital services covered—Continued

Region, State, and plan	All hospital services*	Operating room	Special diets	Drugs	Dressings and casts	Laboratory examinations	Basal metabolism tests	Electrocardiograms	Electroencephalograms	X-ray examinations	X-ray therapy	Radium therapy	Physical therapy	Anesthesia	Oxygen	Administration of blood and plasma
South Atlantic—Con.																
Virginia:																
Richmond		X	X	X	X	X	X	X					X	D	X	X
Roanoke		X	X	X	X	X	X	X		$15			X	D	X	X
West Virginia:																
Bluefield		X	X	X	X	X	X	X	X	X	X		X	C	X	X
Charleston		X	X	X	X	X	X	X	X	X			X	C	X	X
Parkersburg		X	X	X	X	X	X	X	X	X			X	E	X	X
Wheeling		X	X	X	X	X	X	X	X	X	X		X	E	X	X
North Carolina:																
Chapel Hill		X	X	X	X	X	X	X	X	X			X	A	X	
Durham		X	X	X	X	X	X	X		X			X	A	X	
South Carolina		X[20]	X[20]	X[20]	X[20]	X[20]	X[20]	X[20]		X[20]			X[20]	A	X[20]	X[20]
Georgia:																
Atlanta		X	X	X	X	X[27]	X[27]	X[27]		X[27]			X[27]	X[27]	X[27]	X[27]
Columbus		X	X	X	X	X	X	X		(28)				A	X	X
Florida		X	X	X	X	X[29]	X	X	X	X			X	A	X	X
East South Central:																
Kentucky		X	X	X	X	X	X	X		X			X	A	X	X
Tennessee:																
Chattanooga		X	X	X	X	X	X	X	X	X			X		X	X
Memphis	X[30]	(30)	(30)	(30)	(20)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)
Alabama		X	X	X	X	X[9]	X[9]	X[9]	X[9]	X[9]				A	X	X
Mississippi[31]		X	X	X	X	X	X	X		X	X		X	A	X	X
West South Central:																
Arkansas[31]		X	X	X[33]	X	X[32]	X[33]	X[32]	X[32]	X[32]	X[32]		X[32]	A[32]	X	X
Louisiana:																
Baton Rouge[31]		X	X	X	X	X	X	X		X	X		X	A[33]	X	X
New Orleans[31]		X	X	X	X	X	X	X	X	X	X		X		X	X[34]
Oklahoma		X	X	X	X	X	X	X		X	X		X	E[35]	X	X
Texas		X	X	X	X	X	X	X		X	X	X	X	E	X	
Mountain:																
Montana[31]		X	X	X	X	X		X		X			X[36]	A	X	X
Idaho		X	X	X	X	X	X	X		X			X	A	X	X
Wyoming		X	X	X	X	X	X	X	X	X				E	X	X
Colorado		X	X	X	X	X	X	X		X	X		X	E	X	X
New Mexico	X[11]	(11)	(11)	X	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)
Arizona		X	X	X	X	X	X	X	X	X	X		X	A	X	X
Utah		X	X	X	X	X	X	X		X			X	BC	X	X
Pacific:																
Washington		X	X	X	X	X[37]	X[37]	X[37]		X[37]			X[37]	A	X	X
Oregon[31]		X	X	X	X	X	X	X	X	X			X	A	X	X
California:																
Los Angeles[31]		X	X	X	X	X	X	X		X			X	B	X	X
Oakland[31]		X	X	X[38]	X	X	X	X		X			X	A	X[38]	X

See codes and footnotes on next page.

TABLE 2–3.—Blue Cross plans: Hospital services covered—Continued

*The contracts of plans listed in this column do not list all services covered but rather state that all services customarily furnished by the hospitals are covered.
A Supplies, use of equipment, and administration by hospital employee.
B Supplies and use of equipment.
C Administration.
D When rendered as a hospital service.
E Anesthetics and administration thereof.
X Covered.
[1] An allowance up to $100 for drugs, oxygen, and materials used in dressings and casts when used during the period of hospital confinement.
[2] An allowance equal to 50 percent of the first $70 of expense incurred for diagnostic services, plus 100 percent of the expenses of such services in excess of $70. Diagnostic services include but are not limited to X-ray examinations, laboratory examinations, use of cardiographic equipment, and basal metabolism tests.
[3] Use of radium and other radio-active substances when such is customarily provided and billed for by the hospital.
[4] Up to $25.
[5] When rendered by a salaried nurse employee except when under the supervision of a physician anesthesiologist.
[6] And services by persons with whom the hospital has a contractual arrangement, salary or otherwise, in conjunction with the use of supplies and equipment.
[7] The full amount of hospital's usual charges for the "hospital component" of services.
[8] Also supply of blood derivatives and blood plasma.
[9] When provided and billed for as a regular hospital service.
[10] Use of physical therapy equipment.
[11] All services customarily furnished by the hospital.
[12] Drugs not otherwise provided (as in U.S. Pharmacopeia, Homeopathic Pharmacopeia, etc.) for a maximum of $10 per contract year.
[13] And a further credit not to exceed $10 per confinement for hospital charges for any medications not listed (as in U.S. Pharmacopeia, etc.)
[14] Up to $20 for oxygen and use of oxygen equipment.
[15] All services provided and regularly billed for by the hospital, except ambulance and personal convenience items. Includes but not limited to services shown.
[16] All medically necessary ancillary services and procedures provided by the member hospital and performed by employees of said hospital.
[17] "Hospital service" shall mean and comprise room accommodations and all services, equipment, medications and supplies that are furnished, provided by, and used in the hospital.
[18] Only covered for treatment of proven malignancies, except those of the skin.
[19] All hospital services and supplies necessarily furnished. "Services and supplies necessarily furnished" are defined as those services that are reasonably priced, reasonably necessary and customary for the sickness or injury being treated as determined by the Association.
[20] Laboratory and X-ray coverage is sold to Blue Cross only subscribers under a special certificate issued by Blue Shield at an additional rate.
[21] If the employee is a lay anesthetist. If anesthesia is administered by one not a lay anesthetist employed by the hospital, payment will be made for the charges for supplies and use of equipment supplied by the hospital.
[22] Only for diagnostic accident X-rays; excludes nonaccident diagnostic X-rays.
[23] Or by a person whose services are billed for by the hospital.
[24] Excluding chest X-rays provided as routine part of hospital admission.
[25] When administered by a hospital employee.
[26] When customarily provided by the hospital.
[27] When rendered as a regular hospital service customarily provided by the hospital and when service is billed for and payable to the hospital and is performed by a hospital employee.
[28] 50 percent of hospital's charge for X-ray examinations.
[29] Not including section examinations and pathological examinations.
[30] Plan pays 80 percent of all hospital charges to extent rendered by hospital employees.
[31] This most widely held contract also covers surgical-medical benefits.
[32] When administered by full-time employee of hospital who is not compensated by a percentage of fees or other commission arrangement.
[33] Covers anesthesia materials and administration up to $15.
[34] Covers administration of blood and blood plasma up to $10.
[35] General anesthesia only.
[36] If administered by or under the supervision of a registered physical therapist in the employ of the hospital.
[37] When furnished and billed by the hospital.
[38] Drugs and oxygen up to a charge of $10 plus one-half of the charge in excess of $10.

TABLE 2-4.—Blue Cross plans: Outpatient services and benefits in noncontracting hospitals

Region, State, and plan	Outpatient services: Accidents or medical emergencies: Contingency	Outpatient services: Accidents or medical emergencies: Time limit (hours)	Outpatient services: Accidents or medical emergencies: Services provided	Outpatient services: Accidents or medical emergencies: Dollar limit	Outpatient services: Minor surgery: Covered	Outpatient services: Minor surgery: Services provided and dollar limit	Outpatient services: Other	Benefits in noncontracting hospitals: Covers charges up to amount or percent indicated: In plan area: Room	In plan area: Services	Outside plan area in U.S.: Room	Outside plan area in U.S.: Services	Member hospitals of other Blue Cross plans
New England:												
Maine	A	24	All	$30d.	X	All–$30d.	(1)	(2)	(2)	(2)	(2)	A
New Hampshire-Vermont										RRA	$200	D
Massachusetts	A [3]	12	All	([4])	X	All	([5])	[6] RRA	[6] $210	[6] RRA	[6] $210	NS
Rhode Island	A [3]	24	All		X	All	([7])	RRA	90%	RRA	90%	A
Connecticut	A [3]	72	All					RRA	80%	RRA	RB	E
Middle Atlantic:												
New York:												
Albany	A	72	All		X	OR		[8] 80%	80%	[8] 80%	80%	B
Buffalo	A	24	All		X	All		[9] 80%	80%	[9] 80%	80%	NS
Jamestown	A	24	All					$6.50	$100	$6.50	$100	E
New York City	A	24	All	7.25	X	OR–$7.25		[10] $15	[10] 40%	[10] $15	[10] 40%	F
Rochester	A	24	All		X	All	([11])	$20	80%	$20	80%	F
Syracuse	A	24	All	7	X	OR $7	OR–$7	Allowance [12]		Allowance [12]		NS
Utica	A	24	All	7	X	$7		Allowance [13]		Allowance [13]		NS
Watertown	A	24	All [14]		X	All		Allowance [15]		Allowance [15]		D
New Jersey	A		All [10]		X	All [16]	([17])	$20 a day [18]		$20 a day [18]		F
Pennsylvania:												
Allentown	A	24	All		X	All		Allowance [19]		Allowance [19]		F
Harrisburg	A [3]	72	All	10	X	All		Allowance [20]		Allowance [20]		D
Philadelphia	A	48	All		X	All	([21])	Allowance [22]		Allowance [22]		F
Pittsburgh	A	48	All		X	All	([23])	Allowance [24]		Allowance [24]		D
Wilkes-Barre	A [3]	72	All		X [3]	All	([25])	Allowance [26]		Allowance [26]		D [30]
East North Central:												
Ohio:												
Canton	A	24	All		X	All		$10	$100	$10	$100	D
Cincinnati	A	24	All		X [3]	All		$10	$100	$10	$100	E
Cleveland	A	72	All		X [3]	All		[27] $28	[27] 80%	[27] $15	[27] $150	E
Columbus	A [3]	72	All		X	All		$15	$150	$15	$150	D
Lima	A	24	All		X [3]	All		$10	$100	$10	$100	E
Toledo	A	72	All		X [3]	All	([28])	$15 a day		$15 a day		D
Youngstown	A	24	All	20				RB	RB	$6.50	$100	D–E [29]
Indiana	A	72	All		X	All		$12	$100	$12	$100	NS
Illinois:												
Chicago	A [30]	24	All		X [3]	All		Allowance [31]		Allowance [31]		E
Rockford	A	24	All		X	All		RRA	RB	RRA	RB	NS
Michigan	A		All [32]		X	All [32]	([32])	$15 a day [33]		[33] RB	[33] RB	E [33]
Wisconsin	A	48	All		X	All	([34])	90%	90%	90%	90%	E
West North Central:												
Minnesota	A [3]	48	All		X	All	([35])	RB	RB	RB	RB	D
Iowa:												
Des Moines	A	72	All		X	All		[36] 75%	[36] 75%	[36] 75%	[36] 75%	E
Sioux City	A	72	All		X	All		[36] 75%	[36] 75%	[36] 75%	[36] 75%	E
Missouri:												
Kansas City	A [3]	72	All		X [3]	All		$7	$100	$7	$100	E
St. Louis	A	48	All	25	X	$25 [37]		$10 a day [38]		$10 a day [38]		F
North Dakota	A [39]	48	All		X	All		80%	80%	80%	80%	E
Nebraska	A	72	All		X	All		([40])	([40])	([40])	([40])	D [40]
Kansas	A [3]	8 days	All		X	All	([41])	80%	80%	[42] RB	[42] RB	A
South Atlantic:												
Delaware	A	48	All		X	All				$30	80%	B
Maryland	A [3]	72	All		X [3]	All		$20 a day		80%	80%	B
District of Columbia	A [3]	72	All		X [3]	All		85%	85%	85%	85%	B

See codes and footnotes at end of table.

TABLE 2-4.—Blue Cross plans: Outpatient services and benefits in noncontracting hospitals—Continued

Region, State, and plan	Outpatient services: Accidents or medical emergencies: Contingency	Time limit (hours)	Services provided	Dollar limit	Minor surgery: Covered	Services provided and dollar limit	Other	Benefits in noncontracting hospitals: Covers charges up to amount or percent indicated: In plan area: Room	In plan area: Services	Outside plan area in U.S.: Room	Outside plan area in U.S.: Services	Member hospitals of other Blue Cross plans
South Atlantic—Con.												
Virginia:												
Richmond	A	24	All	----------	(43)	----------	----------	$6.50	$100	$6.50	$100	C
Roanoke	A	24	All	(44)	X	All [44]	----------	$6.50	$100	$6.50	$100	C
West Virginia:												
Bluefield	A [3]	24	All	----------	X	All	----------	$8	$80	$8	$100	D
Charleston	A [3]	24	All	----------	X	All	----------	RRA	80%	RRA	80%	D
Parkersburg	A [3]	72	All	----------	X	All	(45)	$12	80%	$12	80%	D
Wheeling	A [3]	72	All	----------	X	All	(46)	70%	70%	70%	70%	C
North Carolina:												
Chapel Hill	A	72	All [47]	----------	X	All	----------	RRA	(48)	RRA	(48)	D [48]
Durham	A [3]	72	All	----------	X	All	----------	RRA	(49)	RRA	(49)	E [49]
South Carolina	A [3]	24	All	15	X	All–$10	----------	80%	80%	80%	80%	D
Georgia:												
Atlanta	A	24	All	----------				[50] NS	[50] NS	[50] NS	[50] NS	A
Columbus	A [3]	24	All	15	X	All–$15	----------	NS	$3	NS	$3	A
Florida	A	72	ER	20				(51)	(51)	(51)	(51)	A
East South Central:												
Kentucky	A	24	All	----------	X	All	----------	Allowance [52]		Allowance [52]		NS
Tennessee:												
Chattanooga	A	24	All	----------				RRA	$3	RRA	$3	D
Memphis	A [3]	24	All–80%	----------				RB	RB	RB	RB	A–80%
Alabama	A	48	All	----------	X	All	----------	$10	75%	$10	75%	D
Mississippi	A [3]	48	All	----------	X	All	----------	$10	$100	$10	$100	A
West South Central:												
Arkansas	A [3]	7 days	All	----------	X	All	----------	75% up to $200				E
Louisiana:												
Baton Rouge	A	24	All	----------	X	All	----------	80%	80%	80%	80%	D
New Orleans	A	24	All	----------				NS	NS	NS	NS	NS
Oklahoma	A	72	All	----------	X	All	----------	$10 a day		$10 a day		D
Texas	A	72	All	----------	X	All	----------	[36] 75%	[36] 75%	[36] 75%	[36] 75%	E
Mountain:												
Montana	A	48	All	----------	X	All	----------	80%	80%	80%	80%	D
Idaho	A	14 days	All	----------	X	All	----------	RRA	80%	RRA	80%	D
Wyoming	E [3]	----------	All	----------	X	All	----------	----------		(53)	(53)	D
Colorado	A	7 days	All	----------	X	All	----------	Allowance [54]		Allowance [54]		E
New Mexico	A	72	All	----------	X	All	(55)	RRA	[56] 75%–$100	RRA	[56] 75%–$100	E
Arizona	A	72	All	----------	X	All	----------	$25 a day		$25 a day		D
Utah	A	48	ER	----------	X	All	----------	[33] $6.50	[33] $100	RB	RB	D
Pacific:												
Washington	A	7 days	All	----------	X	All	----------	----------		RB	RB	D–E [57]
Oregon	A	72	All	----------	X	All	----------	$22	80%	$22	80%	D
California:												
Los Angeles	A	24	All	----------	X	All	----------	$12 a day [58]		RB	RB	D
Oakland	A [3]	24	All	----------	X	All	----------	----------		RB	RB	D

See codes and footnotes on next page.

Outpatient services:
A Accidents. OR Operating room.
E Emergencies. ER Emergency room.
Benefits in noncontracting hospitals:
RRA Regular room allowance. NS Not specified in contract.
RB Regular benefits.
Member hospitals of other Blue Cross plans:
A Service benefits of host plan. If such benefits are less than the allowance would have been against like charges in a participating hospital, member shall be entitled to reimbursement of the difference.
B Services of host plan with limitations of home plan.
C All services of home plan to the extent rendered and billed for by momber hospitals of host plan.
D Service benefits of host plan as designated by home plan (interplan bank benefits).
E Service benefits of home plan.
F Service benefits of host plan or benefits of home plan in noncontracting hospitals, whichever is more favorable to subscriber.

[1] Plaster room for application or removal of casts. X-ray and laboratory examinations directly related to inpatient admission for surgery, when such examinations are made not more than 10 days prior to inpatient admission, will be provided to a value up to $15.

[2] In plan area: At plan's discretion, up to $20 for the first day plus $8 per day for the next 20 days, plus $3.50 per day for the next 100 days. Outside plan area: Subscriber shall receive a stipulated credit (or at the election of plan direct reimbursement) equal to the allowance that would have been provided by a participating hospital in Maine against like charges.

[3] Limited to initial treatment.

[4] No credits in excess of $50 for diagnostic X-rays related to any one accident for an outpatient.

[5] Covers follow-up charges for: Casts or dressings in treatment of fractures or burns; drainage of an acute abscess; spinal fluid examinations or cardiac catheterization; endoscopic examination of the larynx, trachea, bronchi, esophagus, stomach, or bladder; isotope therapy for thyroid abnormalities; X-ray therapy for malignancy or in lieu of surgical treatment of an acute abscess, radium or radon therapy.

[6] In plan area: Reimbursement only for accident, emergency illness, or quarantinable disease. In or outside plan area: Services covered up to the greater amount of $210 or $7 per day.

[7] Full credit for the "hospital component" of diagnostic X-ray, radiotherapy, and diagnostic and therapeutic radioisotopic services when rendered.

[8] In and outside plan area: Covers 80 percent of room and board charges with a minimum of $12 per day and a maximum of $16 per day.

[9] In plan area: Covered only in cases of emergency illness, accident, or injury. In and outside plan area: Covers 80 percent of room and board charges up to $16 per day.

[10] In plan area: Covered only in cases of emergency illness or injury. In or outside plan area: Lesser benefits during partial benefit days.

[11] Covers outpatient radiation therapy, defined diagnostic procedures, and routine pre-admission testing.

[12] In or outside plan area: $16 for a 1-day stay; $14 per day for a 2-through 30-day stay; and $7 per day through the 120th day.

[13] In plan area: Benefits only in case of accident or emergency illness. In or outside plan area: $15 for a 1-day stay; $30 for a 3-day stay; $36 for a 4-day stay; $8.50 per day for 5 or more days.

[14] Hospital services if charges for such do not exceed the amount the Corporation is then paying for such emergency care.

[15] In plan area: Benefits only in event of accident or emergency illness. In or outside plan area: Subscriber entitled to a credit of an amount per day equivalent to the then prevailing rate of payment to participating hospitals, not exceeding the hospital's total charges for services rendered.

[16] All outpatient services except therapy by physical medicine.

[17] Application of plaster casts, defined surgical diagnostic procedures, services in connection with blood transfusions and/or paracenteses.

[18] In or outside plan area: Excludes governmental hospitals; benefits for partial benefit days are $5 per day.

[19] In or outside plan area: $30 for the first day and $8 per day thereafter.

[20] In or outside plan area: Up to $18 for a 1-day stay; $21 for a 2-day stay; $22.50 for a 3-day stay; $7.50 per day for 4 or more days.

[21] Covers diagnostic X-ray, electrocardiographic or electroencephalographic examinations, and basal metabolism tests up to an aggregate of $75 during 12-month period.

[22] In or outside plan area: $30 for the first day and $5 per day thereafter.

[23] Outpatient diagnostic services covered are X-ray examinations, basal metabolism tests, electrocardiograms and electroencephalograms, up to $75 during any consecutive 12-month period; subscriber pays first $5 for all such services rendered within a period of 4 consecutive days. Covers outpatient radiation therapy for treatment of neoplastic or inflammatory disease and physiotherapy, when following inpatient hospitalization; limited to 21 treatments in a period of 12 consecutive months.

[24] In or outside plan area: $25 for the first day and $10 per day thereafter.

[25] Covers X-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests up to an aggregate of $75 for all such services rendered during any 12-month period subject to the payment by the subscriber of the first $5 for any such examination or series of examinations within any period of 4 consecutive days.

[26] In or outside plan area: $30 for the first day and $10 per day thereafter. In all noncontracting hospitals, benefits available only in the event of emergency illness or injury.

[27] In plan area: $28 for room and board plus 80 percent of charges for services or the amount that would be paid such hospital computed in accordance with the contractual rate then in effect and being paid by the Industrial Commission of Ohio, whichever amount is greater. Outside plan area: For subscriber with ward accommodations, $14 a day for room and board and $140 for other covered services.

[28] Outpatient services will be provided for blood transfusions, shock therapy, any outpatient examination or treatment requiring general anesthesia other than dental care.

[29] At the option of the subscriber. In no event will subscriber be entitled to benefits which exceed those to which he is entitled in a participating hospital.

[30] Also covers cases of intentional injuries.

[31] In or outside plan area: Up to $12 for a 1-day stay; $16 for a 2-day stay, $20 for a 3-day stay, $24 for a 4-day stay, and $6 per day thereafter.

[32] All covered hospital services provided; drugs, biologicals and solutions will be furnished only to the extent used in the hospital and only when administered in connection with the use of operating room or surgical treatment rooms, anesthesia, laboratory examinations, physical therapy or other hospital services. Laboratory examinations will be furnished only when related to surgery or treatment of emergencies; physical therapy treatments will be furnished as benefits for a period not exceeding 60 days from initial date of treatment for each condition.

[33] Benefits available only in cases of emergency.

[34] X-ray and radiation therapy for proven malignancies except those of the skin.

[35] Covers deep radiation therapy for treatment of neoplastic or inflammatory diseases; physical medicine up to 30 treatments in 12-month period provided such treatment commences within 7 days of discharge from the hospital as an inpatient; preoperative tests provided (a) within 72 hours of subsequent surgery (b) and if subscriber is confined as a bed patient for such surgery and is entitled to inpatient benefits.

[36] In or outside plan area: Plan will pay 75 percent of the amount it would have paid had the subscriber been hospitalized in a contracting hospital.

[37] A total of $25 for such care received within 1 week from date of first such outpatient care.

[38] In or outside plan area: Benefits available only in cases of emergency illness. Lesser benefits during partial benefit days.

[39] Member is entitled to 2 additional visits for the same injury provided they occur within 60 days of the first outpatient visit.

[40] In plan area: No benefits for services rendered in any noncontracting hospital in a city, town, or locality where a contracting hospital is located. In or outside plan area: Full coverage benefits for 30 days per benefit period. In member hospitals of other Blue Cross plans: If cost to the Association under the provisions of the Service Bank is less than it would have otherwise been, the Association will make payment for such difference. If such cost to the Association is more than it would have otherwise been, the subscriber agrees to reimburse the Association for such excess.

[41] Covered laboratory examinations are included as outpatient benefits when surgery is performed within 72 hours after the tests have been made and the surgery is performed in the same hospital in which the laboratory service was performed; also covers radioactive isotopes, electroencephalograms, and radiation therapy services.

[42] Regular certificate benefits except that benefit period limited to the average length of stay in Kansas member hospital for treatment of the primary condition for which patient is admitted.

[43] No benefits shown in subscriber certificate but Blue Cross Manual indicates benefits provided for minor surgery.

[44] Services limited to initial visit and up to $5 for materials and supplies and $10 for X-ray examinations.

[45] Covers outpatient visits for physical therapy treatments when related to a condition for which hospitalized and when prescribed prior to discharge. Limited to 10 treatments not to exceed $5 per treatment.

[46] Covers physical therapy treatments not to exceed 10 treatments for any 1 condition and not to exceed $5 per treatment.

[47] For emergency first aid.

[48] In and outside plan area: Covers payment of hospital's charges not to exceed specified amounts, including but not limited to $15 for operating room, $12.50 for anesthetic fee, $15 for X-ray examination, $25 for drugs. In member hospitals of other Blue Cross plans: In lieu of these benefits service benefits of host plan may be allowed.

[49] In and outside plan area: Allowance against charges for services equal to 100 percent of daily room allowance for number of days hospitalized. In member hospitals of other Blue Cross plans: Total amount paid will not be less than the total amount which would have been paid to a contracting hospital in the State.

[50] In and outside plan area: Allowance for room and board and services are set forth in an endorsement.

[51] In and outside plan area: Hospital's regular charges but not more than 15 times the maximum amount allowed per day for room and board under the contract.

[52] In and outside plan area: $22 for a 1-day stay, $30 for a 2-day stay. In the event of hospitalization of 3 or more days, an amount not to exceed $12.50 for each day of the entire period of hospitalization.

[53] Outside plan area: Room allowance and charges for services up to 10 times the daily room allowance.

[54] In plan area: $18 for a 1-day stay, $21 for a 2-day stay, $22.50 for a 3-day stay, and $7.50 a day for the 4th through 120th day, or hospital's charges, whichever may be the lesser. Outside plan area: Member allowed amount equal to $15 per day or hospital's charges, whichever may be the lesser.

[55] X-ray and laboratory examinations also covered provided these are related to care for which benefits are available and provided certain conditions are met.

[56] In and outside plan area: In the event of hospitalization for accident or emergency, the $100 maximum shall not apply.

[57] At option of the subscriber.

[58] In plan area: In cases of emergency confinement, benefits are the same as in contracting hospitals.

TABLE 2–5.—Blue Cross plans: Maternity benefits and special conditions covered or not covered

Region, State, and plan	Maternity (normal)			Special conditions covered or not covered											
	Day or dollar limit	Waiting period	Routine nursery care of newborn	Alcoholism	Drug addiction	Self inflicted injuries	Venereal disease	Congenital malformations	Quarantinable diseases	Pre-existing conditions	Sterilizations	Cosmetic surgery	Tonsil and/or adenoid operations	Admissions for diagnostic studies	Other conditions
New England:															
Maine		9	C	C	C	C	C	C [1]	C	NC	C	C	C	C	----------
New Hampshire-Vermont	7d.	9	C	C	C	C	C	9 mo.[2]	C	9 mo.	NC	C	9 mo.	C	(3)
Massachusetts	$100	9	C	C	C	C	C	12 mo.[2]	C	C	C	C [4]	C [5]	(6)	(7)
Rhode Island	[8] $150	7	C	C	C	C	C	C	C	7 mo.[9]	C	C	C	NC	----------
Connecticut	$125	8	NS	30d.[10]	30d.[10]	C	C	C	C	C	C	C	C	C	----------
Middle Atlantic:															
New York:															
Albany	$80	9	C	C	C	C	NC	NC	NC	11 mo.	C	C	6 mo.	NC	----------
Buffalo	10d.	9	C	C	C	C	C	C [1]	C	11 mo.	C	C	6 mo.[11]	NC	----------
Jamestown		9	C	NC	NC	C	C	C	C	C	C	C	C	NC	----------
New York City	$80	10	C	C	C	C	C	11 mo.[2]	C	11 mo.	C	NC	6 mo.[11]	NC	----------
Rochester	[12] $80	10	NC	C	C	C	C	C	C	12 mo.[13]	C	C	6 mo.	C	(14)
Syracuse	$80	10	C	NC	NC	NC	NC	NC	NC [15]	11 mo.	C	NC	6 mo.	NC	----------
Utica	[16] $50	10	C	C	C	C	NC	NC	NC	11 mo.	C	C	6 mo.[11]	NC	----------
Watertown	$120	9	NC	NC	NC	C	NC	C	C	12 mo.	C	NC	6 mo.	NC	----------
New Jersey	7d.	8	C	20d.[17]	C	C	C	C	C	C	C	C	C	(18)	
Pennsylvania:															
Allentown	$75	8	C	30d.[17]	30d.[17]	C	C	C	C	12 mo.	C	C	C [11]	NC	----------
Harrisburg	8d.	9	C	30d.[19]	30d.[19]	C	C	NC [20]	C	12 mo.	C	NC	6 mo.	NC	----------
Philadelphia	6d.	8	C	20d.[17]	20d.[17]	C	C	C	C	12 mo.	C	C	C [11]	NC	----------
Pittsburgh	10d.	9	C	30d.[21]	30d.[21]	C	C	C	C	C	C	C	6 mo.	NC	----------
Wilkes-Barre		9	C	C	C	C	C	C [1]	C	NC	C	C	C	NC	----------
East North Central:															
Ohio:															
Canton		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Cincinnati		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Cleveland		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Columbus	$80	9	C	NC	NC	C	C	C	C	C	C	NC	C	NC	----------
Lima		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Toledo		9	C	(22)	(22)	C	C	C	C	C	C	C	C	NC	----------
Youngstown		9	C	NC	NC	C	C	C	C	C	C	C	C	C	----------
Indiana		9	C	C	C	C	C	C	C	9 mo.	C	C	C	NC	----------
Illinois:															
Chicago		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Rockford	[23] NS	10	C	C	C	C	C	C	C	10 mo.	C	NC	6 mo.	NC	----------
Michigan		9	C	30d.[24]	30d.[24]	C	C	C	C	C	C	C	C	NC	----------
Wisconsin		9	C	C	C	C	C	C	C	9 mo.	C	C	9 mo.	NC	----------
West North Central:															
Minnesota		9	C	C	C	C	C	C	C	C	C	C	C	NC	----------
Iowa:															
Des Moines		9	C	30d.[10]	30d.[10]	C	C	C	C	C	C	NC [25]	C	NC	----------
Sioux City		9	C	30d.[10]	30d.[10]	C	C	C	C	11 mo.	C	NC [25]	9 mo.	NC	----------
Missouri:															
Kansas City	10d.	9	C	14d.[21]	14d.[21]	C	C	C	C	12 mo.	C	NC	C	NC	----------
St. Louis		9	C	14d.[17]	14d.[17]	C	C	C	C	NC	C	NC	C	C	----------
North Dakota		9	C	70d.[10]	70d.[10]	C	C	C	C	9 mo.	C	NC	9 mo.	NC	----------
Nebraska		9	C	30d.[10]	30d.[10]	NC	C	C	C	9 mo.	C	C	9 mo.	NC	----------
Kansas		8	C	30d.[17]	30d.[17]	C	C	C	C	C	C	NC [20]	C	C	----------
South Atlantic:															
Delaware	$200	9	NC	C	C	C	C	12 mo.	C	12 mo.	C	NC	C	C	----------
Maryland	$75	8	C	C	C	C	C	9 mo.	C	9 mo.	C	NC	C	NC	----------
District of Columbia	$100	10	C	C	C	C	C	10 mo.	C	10 mo.	C	C	10 mo.	C	----------

See codes and footnotes at end of table.

TABLE 2–5.—Blue Cross plans: Maternity benefits and special conditions covered or not covered—Continued

Region, State, and plan	Maternity (normal)			Special conditions covered or not covered											
	Day or dollar limit	Waiting period	Routine nursery care of newborn	Alcoholism	Drug addiction	Self inflicted injuries	Venereal disease	Congenital malformations	Quarantinable diseases	Preexisting conditions	Sterilizations	Cosmetic surgery	Tonsil and/or adenoid operations	Admissions for diagnostic studies	Other conditions
South Atlantic—Con.															
Virginia:															
Richmond	$80	9	C	NC	NC	C	C	C	C	C	C	C	C	NC	
Roanoke	10d.	9	C	NC	NC	C	C	C	C	12 mo.	C	NC	6 mo.[27]	NC	
West Virginia:															
Bluefield		9	C	NC	NC	C	C	C	C	9 mo.	C	NC	9 mo.	NC	
Charleston	10d.	9	C	NC	NC	C	C	C	C	9 mo.	C	C	9 mo.	NC	
Parkersburg	10d.	9	C	NC	NC	C	C	C	C	6 mo.	C	C	6 mo.	NC	
Wheeling		9	C	NC	NC	C	C	C	C	9 mo.	C	C	9 mo.	NC	
North Carolina:															
Chapel Hill		9	NC	NC	NC	C	NC	C	C	24 mo.	C	NC[28]	C	NC	
Durham		9	NC	C	C	C	C	C	C	24 mo.	C	C	6 mo.	NC	
South Carolina	10d.	10	C	15d.[17]	15d.[17]	C	C	12 mo.	C	12 mo.	C	NC	6 mo.	NC	(29)
Georgia:															
Atlanta		9	C	NC	NC	C	C	C	C	C	C	C	C	NC	
Columbus	7d.	9	C[30]	NC	NC	C	C	C	C	12 mo.	C	C	C	NC	
Florida	$80	9	C	C	C	C	C	C	C	C	C	C	C[31]	NC	
East South Central:															
Kentucky	10d.	9	C	C	C	C	C	C	C	12 mo.	C	C	C	NC	
Tennessee:															
Chattanooga	10d.	9	C[30]	NC	NC	C	C	C	C	12 mo.	C	C	12 mo.	NC	
Memphis	14d.	10	C	NC	NC	C	NC	C	C	6 mo.	C	C	12 mo.	C	
Alabama	10d.	9	C	C	C	C	C	C	C	12 mo.	C	NC	9 mo.	NC	
Mississippi	10d.	9	NC	NC	C	C	C	NC	C	12 mo.	9 mo.	NC	C	NC	
West South Central:															
Arkansas		9	C	NC	NC	NC	C	C	C	12 mo.	C	NC	12 mo.	NC	
Louisiana:															
Baton Rouge	10d.	10	C	NC	NC	C	C	C	C	12 mo.	C	NC	12 mo.[32]	NC	(33)
New Orleans	10d.	9	NC	NC	NC	C	C	C	C	NC	C	NC	C	NC	
Oklahoma	10d.	9	C	NC	NC	C	C	C	C	C	C	NC	C	NC[34]	
Texas	NS	NS	NS	C	C	C	C	C	C	C	C	C	C	NC	
Mountain:															
Montana		9	C	C	C	C	C	C	C	12 mo.	C	NC	C	C	
Idaho	$75	9	C	C	C	C	C	C	C	11 mo.	C	NC	11 mo.	NC	
Wyoming	10d.	9	NC	NC	NC	NC	C	C	C	11 mo.	C	NC	C	NC	
Colorado		9	C	21d.[35]	C	C	C	C	C	11 mo.	C	C	11 mo.	NC	(36)
New Mexico		9	C	30d.[37]	30d.[37]	C	C	C[37]	C	C[37]	C	NC	6 mo.	NC	(32)
Arizona	$80	9	C	30d.[21]	30d.[21]	C	C	11 mo.	C	11 mo.	NC	NC	6 mo.	NC	
Utah	10d.	9	C	C	C	C	C	C	C	C	C	NC	C	NC	
Pacific:															
Washington	[38] $100	9	C	35d.[39]	C	C	C	6 mo.	C	6 mo.	C	NC	6 mo.	NC	(40)
Oregon	$100	9	C	C	C	C	C	C	C	6 mo.	C	C	6 mo.	NC	
California:															
Los Angeles	$50	9	NC	C	C	C	C	C	C	C	C	NC[41]	C	NC	
Oakland	$50	9	C	C	C	C	C	C	C	C	C	C	C	NC	

See codes and footnotes on next page.

TABLE 2–5.—Blue Cross plans: Maternity benefits and special conditions covered or not covered—Continued

C Covered.
NC Not covered.
NS Not specified in contract.
[1] Covers congenital malformations in covered newborn only.
[2] Waiting period not applicable for members born after effective date of contract.
[3] Hernia, varicose veins, hemorrhoids, dental care, and any condition involving the female genital system are covered only after a waiting period of 9 months.
[4] Covered if not pre-existing, but limitation does not apply to a member under age 19 who has been covered since birth or for 12 months prior to admission.
[5] Limited to 1 day for a member 12 years of age and under, and to 2 days for a minor dependent member over age 12 after a 12-month waiting period. Restrictions and waiting period do not apply to adults.
[6] Diagnostic X-ray services undertaken within a 30-day period.
[7] 12 months waiting period for a considerable number of conditions including hernias, asthma, emphysema, gall bladder, skin malignant neoplasms, and hemorrhoids.
[8] If care beyond the fifth day of hospitalization is medically necessary, the subscriber shall also be entitled to credits set forth for "Medical and surgical cases," beginning on the sixth day.
[9] No waiting period for groups meeting certain enrollment requirements.
[10] With admissions separated by 180 days.
[11] Limited for a member under age 12 years to 1 day and for a member over age 12 to 2 days.
[12] Or $10 per day, whichever is greater.
[13] Waiting period applicable only for those family members added after the effective date of contract.
[14] Waiting period of 1 year for benefits for hernia, hemorrhoids and other rectal conditions, duodenal or gastric ulcers, gall bladder conditions or disease, varicose veins, and thyroid conditions or complication thereof.
[15] Except for scarlet fever, poliomyelitis, epidemic meningitis, diptheria, and smallpox.
[16] Or $8 per day for 10 days, whichever is greater.
[17] Per contract year.
[18] Admissions for certain defined surgical diagnostic procedures, provided no other diagnostic studies are performed, are covered. (Covers admissions for angiocardiography, arteriography, esophagoscopy, myelography, peritoneoscopy, pneumoencephalography, thorascopy, and ventrieulography.)
[19] During life.
[20] Not covered unless for functional purposes.
[21] In a 12-month period.
[22] 31 days per confinement in the aggregate for alcoholism, drug addiction, and nervous and mental disorders.
[23] Varies with specifications on individual certificates—limited to 10 days' care on certificates having both semiprivate and private room allowances; and limited to 10 times the pegged room indemnity allowance.
[24] Per admission.
[25] Cosmetic surgery for beautifying purposes is not covered except for correction of defects incurred through accidental bodily injury sustained while covered under contract.
[26] Not covered for subscribers aged 21 and over except for accidental injuries incurred after the effective date.
[27] Limited to 1-day stay except for complications.
[28] Except in cases of accidental injuries.
[29] Waiting period for hemorrhoids is 6 months.
[30] Limited to $3 a day.
[31] Limited to 1 day's care for a child under age 14 and to 2 days' care for other subscribers.
[32] Benefits for tonsillectomy and/or adenoidectomy limited to 1 day.
[33] Services excluded during first year of coverage for surgery or treatment of reproductive organs, hernia, and hemorrhoids.
[34] Covered if the necessary diagnostic services could only be provided if the patient is hospitalized.
[35] Limited to 21 days in member hospital during life.
[36] 11-month waiting period for benefits for gall bladder diseases and ulcers of the stomach and duodenum.
[37] Waiting period of 9 months for listed diseases including alcoholism, arthritis, asthma, cancer, disorder of the gall bladder, genitalia disorders, tumors, ulcers, and disorders of the urinary or cardiovascular system. Benefits for alcoholism and drug addiction limited to 30 days per admission.
[38] Or $15 a day for 10 days, whichever is greater.
[39] Per year and only in general hospitals.
[40] Care for hernia, cardiac, vascular, renal, and cancerous or tumorous conditions only after a 6-month waiting period.
[41] Not covered unless for functional disorders or as a result of accidents occurring while covered under contract.

TABLE 2–6.—Blue Cross plans: Age limits and coordination of benefit provisions

Region, State, and plan	Age limits: Newborn (days after birth)	Age limits: Unmarried children (years)	Unmarried children over limit incapable of self-support	Coordination of benefits provisions
New England:				
Maine		19		
N.H.-Vt.		19		
Massachusetts		19	C	
Rhode Island	(1)	19	C	
Connecticut	15	19	C	
Middle Atlantic:				
New York:				
Albany		19		
Buffalo		19	C	
Jamestown		19	C	
New York City		19		
Rochester	(2)	19	C	
Syracuse		19		
Utica	14	19	C	
Watertown		19		
New Jersey		19		
Pennsylvania:				
Allentown		19	C to 25	
Harrisburg		19		
Philadelphia		19	C to 25	
Pittsburgh	(3)	19		
Wilkes-Barre		19		
East North Central:				
Ohio:				
Canton		19		
Cincinnati		[4] 19	C to 23	
Cleveland		19		
Columbus		19		X
Lima		[4] 19	C to 23	
Toledo		19		
Youngstown		19		
Indiana		19		
Illinois:				
Chicago		19		
Rockford		19		
Michigan		19		
Wisconsin		19		
West North Central:				
Minnesota		19		
Iowa:				
Des Moines		[5] 19	C	X
Sioux City		[5] 19	C	
Missouri:				
Kansas City		19		X
St. Louis		19		
North Dakota		[5] 19	C	
Nebraska		19	C	
Kansas		21		X
South Atlantic:				
Delaware		19	C	X
Maryland		19	C	
District of Columbia	14	19	C	X
Virginia:				
Richmond		19		
Roanoke		19		
West Virginia:				
Bluefield		19		
Charlestown		19		
Parkersburg		19		
Wheeling		19		
North Carolina:				
Chapel Hill		19		
Durham		19		
South Carolina		19		
Georgia:				
Atlanta		19		
Columbus	15	19		
Florida		19		
East South Central:				
Kentucky		19		
Tennessee:				
Chattanooga	15	19		
Memphis		19		
Alabama		19		
Mississippi	14	19		
West South Central:				
Arkansas		19		
Louisiana:				
Baton Rouge		[6] 19		
New Orleans	11	19		
Oklahoma		19		X
Texas		19		X
Mountain:				
Montana		19		
Idaho		19		X
Wyoming		19		
Colorado		19		
New Mexico		19	C	
Arizona		19		
Utah		19		
Pacific:				
Washington		19		X
Oregon	14	19		
California:				
Los Angeles	14	19		
Oakland	30	19		

C Covered.
X Included.

[1] Newborn child shall become a subscriber when a major surgical procedure is performed on the child, when the mother or child is discharged from the hospital, or when the child has attained the age of 14 days, whichever event shall occur first.

[2] Date of discharge of the mother or 10 days, whichever occurs first, except that a premature infant and an infant with a congenital condition or illness shall be included from birth, provided special unusually expensive care is required in excess of routine nursery care.

[3] Dependent child is entitled to coverage as a subscriber beginning with the day the mother ceases to receive maternity care under the subscription agreement, or beginning with the day of birth if the mother is not entitled to maternity care under the subscription agreement.

[4] Unmarried children under age 23 who are full-time students in an educational institution may also be covered.

[5] Unmarried children who are full-time students at an accredited college, university, or nursing school are covered regardless of age.

[6] Unmarried children between the ages of 19 to 24 who are enrolled at a college or university are also covered.

Chapter 3

BLUE SHIELD PLANS

THE BENEFIT provisions of the most widely held group contracts[1] of the 72 Blue Shield plans in the United States are summarized in tables 3–1 through 3–6. The total enrollment of the plans is shown in table 3–1 to indicate the relative importance of the various plans with regard to the number of persons served. The specific enrollment of the programs described was not obtained.

Subscription Rates

Data on the monthly subscription charges for the most widely held contract were not available for 13 plans. In many of these cases the plans simply reported to the national organization that rates are determined on the basis of group characteristics. In other cases several rates were reported in accordance with contract options and, thus, a single rate could not be cited here.

Among the plans for which rates were available, the monthly subscription charges for one person ranged from $0.65 to $12.35 with a median of $2.04. The modal charge was between $1 and $2. For a few plans the one-person rate differed for male and female subscribers—charges being lower for males. Subscription rates for a family ranged from $2.20 to $28.70 with a median of $6.50. These data are summarized below.

One person, all plans	72
Rate not available	13
Under $1	1
$1.00 to $1.50	14
$1.51 to $2.00	14
$2.01 to $2.50	8
$2.51 to $3.00	3
$3.01 to $3.50	4
$3.51 to $4.00	6
$4.01 or more	9
Median rate	$2.04
Family, all plans	72
Rate not available	13
$2 to $2.99	4
$3 to $3.99	3
$4 to $4.99	9
$5 to $5.99	8
$6 to $6.99	11
$7 to $7.99	6
$8 to $8.99	2
$9 to $9.99	6
$10 or more	10
Median rate	$6.50

It should be noted that the rates listed for six of these plans include the cost of hospitalization benefits. Considering only the 53 physician-service rates listed, the maximum rates are $5.20 for individuals and $13.00 for families. The medians are $1.90 and $6.05 for single and family coverages, respectively.

[1] For a few of the plans, the Government-wide Service Benefit Plan was the most widely held contract. In these instances the second most widely held contract was substituted.

Type of Benefits and Income Limits

The benefits offered to Blue Shield subscribers are of three broad types: "indemnity," "full service," and "partial service." Under plans providing indemnity benefits, subscribers are entitled to fixed allowances for each service and the physician is free to charge the subscriber the difference between his normal fee and the amount he receives from the plan. "Full service" plans provide benefits in the form of service and participating physicians agree to accept the plan's payments as full payment for their services, regardless of the subscriber's income. Some of these plans pay physicians on the basis of their usual, customary, and reasonable charges or so-called prevailing fees. "Partial service" plans provide benefits on a full coverage basis for those subscribers whose income is below a specified amount and provide indemnity benefits for those subscribers whose income is above this limit. (In other words, participating physicians agree to accept the plan's scheduled allowances as full payment in the case of subscribers with incomes under the specified amount and have the right to charge more to those with incomes over this level.)

Under their most widely held contracts, 15 plans provide indemnity benefits, 14 offer full service benefits, and the remaining 43 provide benefits on a partial service basis. The distribution of the partial service plans by income limits for a single person and a family is shown below:

One person	43
$2,000–$2,999	3
$3,000–$3,999	9
$4,000–$4,999	12
$5,000–$5,999	4
$6,000 or more	15
Family	[1] 43
$4,000–$4,999	11
$5,000–$5,999	3
$6,000–$6,999	13
$7,000–$7,999	10
$8,000–$8,999	2
$9,000–$9,999	1
$10,000 or more	3

[1] A few plans have a separate income limit for husband and wife without children, or for subscriber and a minor dependent.

In some instances indemnity rather than service benefits may be provided to those subscribers whose incomes fall below the stipulated level. This might be the case, for example, if the subscriber is entitled to receive benefits or compensation for the same or similar services from both Blue Shield and another health insurance plan, or from a liable third party, or if, as a hospital bed patient, he chooses accommodations more expensive than semiprivate accommodations. In these circumstances, participating physicians in some plans would be free to charge more.

Blue Shield plans are in the midst of change as to types of benefits offered. Up until, say, 5 years ago nearly all plans paid physicians on the basis of a set schedule of fees or allowances. Since then there has been widespread change toward arrangements under which physicians are paid on the basis of usual and customary charges, reasonable charges, or prevailing fees. (The terms used by the plans vary but all involve the concept of the physician being paid his usual or regular fee for a service, provided it is regarded as reasonable in the light of fees charged by similarly qualified physicians in the area for the same service.) Movement in this direction antedated Medicare—under which physicians are paid on the basis of usual, customary, and reasonable charges—but adoption of this basis of remuneration under Medicare and some State Medicaid programs greatly strengthened the development. At present the majority of Blue Shield plans pay usual, customary, and reasonable charges or prevailing charges under their contracts for one or more large groups, e.g., under the high option of the Federal employee plan or for the steel and/or auto workers, or under one or more contracts offered the general public. Thus far, however, only eight plans are paying physicians on a usual, customary, and reasonable charge or prevailing charge basis under their most widely held contracts.

Blue Cross affiliation.—In most areas, the Blue Shield plan is affiliated with the Blue Cross plan or plans serving the area.[2] However, as shown in table 3–1, 16 Blue Shield plans are not closely affiliated with a Blue Cross plan and these generally provide hospitalization benefits in addition to surgical-medical benefits.

[2] One relationship is that in which the two organizations, though established as separate corporations each with its own board of directors, are completely unified administratively, i.e., the same individual serves as executive director for both plans and there is a single staff. Another type of relationship is that in which the plans are separate corporations with separate boards and executive directors and to some extent separate staffs, but in which there is administrative coordination of the plans' activities. In a few other cases the same corporation operates as both an approved Blue Cross and Blue Shield plan.

Services Covered

Table 3–2 outlines the inpatient and outpatient services covered by each plan under its most widely held contract. Inpatient services refer to those services available to a hospital bed patient. Outpatient services refer to those available to ambulatory patients either in the doctor's office or in a hospital outpatient department. Services available in the patient's home have not been taken into account, since these are of minor or negligible importance. An exception is general medical visits, which, if covered for office care, are also usually covered for visits in the patient's home. The tabulation excludes consideration of benefits provided under major medical, extended benefit, catastrophic illness, or related riders, which in some cases are most widely held in addition to basic certificates.

Obstetrics.—All of the contracts analyzed cover inpatient obstetrical services for eligible subscribers. While the contracts of two of the plans (Kansas and California) do not cover normal delivery, benefits for these services are available by endorsement and such endorsements are customarily part of the marketed packages. In virtually all cases, obstetrical benefits are available only to the employee or wife under a husband-and-wife or family contract.

The plans vary widely as to whether coverage is for the delivery only or includes prenatal and postnatal care. This last is shown in table 3–4. Twenty-one plans cover prenatal care, 30 do not,[3] and in 21 plans the contract does not specify; it may be presumed that these latter plans do not cover it. The situation is roughly the same for postnatal care—25 plans cover it, three cover it only in the hospital, 20 do not cover it, and 24 do not specify.

In very few cases is full obstetrical care, including prenatal and postnatal care, provided as a full service benefit. Frequently obstetrical delivery is specifically excluded from the service benefit provisions or the contract does not cover prenatal and postnatal care, thus leaving the physician free to charge extra for these services over and above the payment received from the plan for the delivery itself.

Surgery.—All of the plans cover surgery whether performed within or outside the hospital. With few exceptions the plans cover this service in the hospital, the office, the outpatient department, or the patient's home. (Surgery includes not only cutting operations, but also reduction of fracture, treatment of a dislocated limb by manipulation or reduction, lancing of a boil, removal of foreign substances from the skin or eye, etc.) The contracts do not always make it plain that they cover the physician's charge for preoperative and postoperative care. Generally any specification of the period of postoperative care to be included as part of a surgical operation is set forth in the plan's schedule of fees or allowances, and not in the subscriber contract. This period of care generally varies with the severity of the operation.

Five plans have limitations on the maximum liability of the plan for surgery. Under its most widely held contract, the South Dakota plan has a maximum liability of $5,000 for all surgical services during the lifetime of the subscriber. Connecticut has a liability of $2,100 per subscriber for all surgical and obstetrical services received during the calendar year. The two Wisconsin plans specify aggregate liabilities per period of illness for surgical and other covered services. The St. Louis contract limits its liability to $200 per contract year for any one condition.

Medical visits.—All except two plans (Jamestown, N.Y., and Atlanta, Ga.) under their most widely held contract cover in-hospital medical visits.[4] Most plans begin coverage with the first day of hospitalization. However, one plan begins coverage on the second day, two on the third day, nine on the fourth day, and one on the fifth day (see table 3–4). Most plans that cover this service from the first day pay a larger fee or allowance for the first day of care, and then a smaller fee or allowance for each subsequent day with, in many cases, a further decrease after a specified number of days. In virtually all plans the benefit for in-hospital visits is stated in terms of number of days of care in the hospital, i.e., irrespective of whether the physician sees the patient on a particular

[3] Includes five plans that cover it only in the hospital, i.e., immediately preceding delivery.

[4] These two plans do offer such benefits by riders, but apparently these riders *in toto* (and accordingly, no single rider) are held by a majority of subscribers holding the most widely held contract.

day or sees him more than once on any day.

The maximum number of days of care for which the plan provides benefits is usually the same as the number of days of hospital care provided by the companion Blue Cross plan. However, some plans state the maximum benefit in terms of dollars. The distribution of plans by maximum number of days of in-hospital care or maximum dollar benefits is as follows:

All plans	72
No benefit	2
No maximum cited	4
Benefit not specified	2
Plans with maximum benefit in number of days	58
21–31 days	7
50	1
67–70	17
90–100	4
120	19
150–201	5
365	5
Plans with maximum benefit in dollars	6
Under $200	2
$201–$400	2
$400 or more	2

Most plans specify that any readmission within 90 days of discharge from a hospital is to be considered as a continuation of the former period of care, and any admission after 90 days as a new admission. A few plans have other limits.

Approximately one-third (26) of the contracts include special provisions for intensive care by physicians in the hospital, i.e., for covering physician charges in full or making extra allowances in cases where a patient is critically ill and may require physician attendance, care or study definitely in excess of that required for the usual medical case in the hospital. These plans provide special remuneration for attendance in such cases. While the other plans do not specifically mention "intensive care" in their contracts, probably most of those that provide partial or full service benefits provide at their discretion commensurately larger payments or allowances to physicians in cases that require care beyond the normal or average.

Whereas all except two plans cover physician visits in the hospital, only 11 plans provide any coverage of physician visits in the office or home.[5] Not included in this count are a few plans that cover such visits only in accident or medical emergency cases or only after discharge from the hospital and for care of the condition for which hospitalized. Only two of these plans (New Hampshire-Vermont and Pennsylvania) are in the East; the rest are all in western States—Idaho, California, Oregon, Washington, and Hawaii. Several of the plans covering office and home visits (Pennsylvania and the Bremerton, Seattle, Spokane, and Wenatchee plans in Washington) do so only for the employed subscriber and not for dependents. The Pennsylvania plan begins coverage only with the fourth visit and limits visits to 21 per year. Most of the other plans place limits on the number of visits that will be paid for and some require the patient to pay a certain amount per visit or a certain proportion of the charge.

X-ray examinations.—As was noted in the review of the most widely held Blue Cross contracts, X-ray, laboratory, anesthesia, and physical therapy services for hospital inpatients are variously regarded as either hospital or professional services and are thus appropriately covered by one or the other of the Blue plans. Or, in some cases, the services are regarded as having both hospital and professional components, with the hospital component covered by Blue Cross and the professional component by Blue Shield. Since the great majority of Blue Cross and Blue Shield plans serving the same area are affiliated and coordinate their coverage with each other, a subscriber not covered for these services under Blue Cross will probably be covered for them by Blue Shield, or vice versa, or Blue Cross and Blue Shield will together provide coverage.

The situation is not quite the same as regards coverage of ambulatory patients. These services when provided by physicians in their private offices are unequivocally professional services and thus normally covered only by Blue Shield. When provided in hospital outpatient departments, the same problem of whether the services are to be regarded as hospital or professional services again arises. However, it may be noted that physicians in these specialties are very reluctant to have Blue Cross cover these services in hospital outpatient departments without the same services being covered by Blue Shield in physician offices, for private practitioners do not wish to lose patients to hospitals.

The situation as regards coverage by Blue Shield of diagnostic X-ray services for hospital inpatients and ambulatory patients (served in doctors' offices or in hospital outpatient departments) is summarized below:

[5] Although not shown in table 3–2, all or virtually all of the plans shown as covering physician visits in the office also provide some coverage of visits in the home.

	Inpatients	*Outpatients*
All plans	72	72
Covered without special limitation [1]	21	13
Covered with a deductible for each procedure or up to specific dollar limit per year or a percent of charges, or some combination of these [2]	22	24
Covered only for accident cases or when followed by related surgery or inpatient medical care	8	18
Not covered	21	17

[1] Some of these have maximums on amounts of benefits for all services in a year.
[2] Some of these provide better coverage for accidents or when followed by related surgery.

The fact that the majority of Blue Shield plans do not cover X-ray examinations for hospital inpatients at all, or provide only partial coverage, is perhaps not of marked significance since Blue Cross in most cases provides full or substantial coverage. More important is the showing for X-ray examinations in doctors' offices, since here Blue Cross does not figure.

Thirteen plans provide full coverage of X-ray examinations for ambulatory patients.[6] Another 24 plans provide a partial coverage, that is, pay up to a specified dollar limit or a specified percentage of charges. Their coverage ranges from quite poor to fairly good, depending upon the particular limitations or "co-pay" provisions in effect. Thus one plan covers such X-ray examinations only up to a total of $20 a year, which is, of course, only token coverage. Another covers such services up to $150 a year, which is substantial coverage. Some plans pay only 50 percent of X-ray charges; others pay 80 percent. The Michigan plan—to give an example of another arrangement—provides that the patient must pay $5 or 10 percent of the scheduled fee, whichever is greater, for each service.

The 18 plans that cover X-rays (to a lesser or greater extent) only for accident cases or only when followed by related surgery or in-hospital medical care are apparently feeling their way toward coverage of X-ray examinations for ambulatory patients. Another 17 provide no coverage whatever under their most widely held contracts.

This matter is dwelt on since coverage of X-ray and other diagnostic services for ambulatory patients can be an important means of keeping hospital admissions to a necessary minimum. When these services are covered for hospital inpatients but not for ambulatory patients, patients will sometimes request hospitalization and physicians will recommend it for them so that insurance will cover the costs.

Radiation therapy.—X-ray therapy in hospitals is generally considered to be a professional service—at any rate it is covered, in full or to some extent, by only a minority (29) of the Blue Cross plans. Radium therapy is covered by only 18 Blue Cross plans. The great majority of Blue Shield plans cover both services, in full or with limitations, both for hospital inpatients and ambulatory patients.

Of the 72 Blue Shield plans, 32 provide X-ray therapy benefits for hospital inpatients without special limitations (two of these have maximums on the amount of benefits payable for all services) or qualifications. (Some of these plans provide full service benefits, some partial service benefits, and some indemnity allowances.) Twenty-six plans provide benefits subject to some special qualification or limitation. In the great majority of cases the limitation is a maximum on total benefits for this service within a year's period. (The range of these maximums is great—from, say, as little as $100 to as much as $500.) [7] A few specify that the treatments must be for malignancies or in lieu of surgery. Fourteen plans do not provide any benefit for this service.

The situation with respect to X-ray therapy for ambulatory patients is approximately the same—in general the same plans provide the same benefits for inpatients or outpatients. Virtually the same situation holds for radium therapy in or out of hospitals.

Pathology.—Pathology service for inpatients is covered without special limitation by 18 plans, covered with qualifications and limitations (e.g., maximum limit on benefits per year or condition, "co-pay" provisions, provisions that the service will be paid for only when followed by surgery) by 15 plans, and not covered by 39 plans. Again, these limitations are not important in most cases since most Blue Cross plans cover laboratory and pathology examinations.

[6] In some of these cases the plan has a schedule of fees or allowances for X-ray services and doctors can charge extra to patients who are over the income limit for service benefits.

[7] One may speculate as to the reasons for these dollar limitations. If they are present as a means of controlling unnecessary or excessive utilization, they appear to be an awkward means of achieving this objective.

Pathology services for ambulatory patients are covered by 15 plans without special limitations (coverage can be service, partial service, or indemnity), and are covered by an additional 17 plans with some qualifications or limitations. In three plans the limitation is that the service will be paid for only if followed by related surgery within a specified period; in 10 cases a maximum is placed on amount of benefits in a year or per condition—several plans have a maximum of only $10, $15, or $20, with the highest being $100—and in other cases benefits are subject to a deductible or the plan pays only a percentage of the fee. Forty most widely held contracts do not cover pathology services for ambulatory patients at all.

Anesthesia.—All except three plans cover anesthesia for hospital inpatients (on a service, partial service, or indemnity basis) under their most widely held contract. The three that do not are Connecticut, Pennsylvania, and Mississippi.[8] An additional eight plans do not cover anesthesia for ambulatory patients.

Other services.—Physical therapy is specifically covered by 11 plans in the hospital, and by eight for ambulatory patients. Electro-shock is covered by 13 plans for inpatients, and by nine for outpatients. Forty plans provide benefits for medical consultation services for hospital inpatients. Several plans limit the number of consultations per admission or per consultant.

Combined Blue Plan Coverage for Inpatient X-Ray and Laboratory Examinations

This review has discussed the extent to which Blue Cross and Blue Shield plans separately cover certain services variously regarded as hospital or professional services or as having components of both. It seems desirable at this point to consider the extent to which some of these services are covered for Blue plan subscribers by one or the other of the plans or by both togeher. Such an analysis is made in table 3–3 for inpatient X-ray and laboratory examinations.

These services are covered in full or in part under all coordinated or joint Blue Cross-Blue Shield plans and in all cases where a Blue Cross plan not affiliated with a Blue Shield plan offers surgical-medical benefits, or a Blue Shield plan not affiliated with a Blue Cross plan offers hospitalization benefits. In other words, there is no situation in which one or the other Blue plan or both together do not provide some coverage of these two services. In a total of 91 situations (i.e., pairs of coordinated or joint Blue Cross-Blue Shield plans or unaffiliated Blue Cross and Blue Shield plans) for which data are available, full coverage of inpatient X-ray examinations was obtainable in 71 cases and partial coverage was obtainable in 20 cases. In the case of laboratory examinations for inpatients, out of 90 situations for which data are available, full coverage was obtainable in 80 situations and partial coverage in the rest. The number of footnotes reflect the complexities of the situations and in some cases the limitations of coverage.

In a considerable number of cases each of a pair of Blue Cross and Blue Shield plans provides some coverage. In a few cases this is due to Blue Cross covering the hospital component of the service and Blue Shield the professional component. Much more frequently, the Blue Cross plan provides full coverage of these benefits when provided as an institutional service and the Blue Shield plan provides for inpatients the same restricted X-ray and laboratory professional benefits that it provides for ambulatory patients. In these instances the Blue Shield coverage for inpatients appears to add little or nothing to the typical patient's coverage.

There are 68 instances of paired (coordinated or joint) Blue Cross-Blue Shield plans. Of these, inpatient X-ray examinations are covered by both Blue Cross and Blue Shield in 32 cases, by Blue Cross only in 24 cases, and by Blue Shield only in 12 cases. The situation regarding coverage of inpatient X-ray and laboratory services by coordinated plans is summarized below:

Inpatient X-ray examinations:	*Number of cases*	*Full coverage*	*Partial coverage*
Covered by both Blue Cross and Blue Shield	32	28	4
Covered by Blue Cross only	24	22	2
Covered by Blue Shield only	12	4	8
Inpatient laboratory examinations:			
Covered by Blue Cross and Blue Shield	21	21	0
Covered by Blue Cross only	42	40	2
Covered by Blue Shield only	5	3	2

[8] Such coverage is available under endorsements, which are probably purchased by most subscribers.

Although, no Blue plan member fails to have some coverage as a hospital inpatient of both X-ray and laboratory examinations under the most widely held contracts, in some situations the coverage is quite limited. For example, the New Hampshire-Vermont plans under their most widely held contracts cover X-ray examinations for inpatients only up to $25 per admission. The Syracuse Blue plans cover only 50 percent of charges for X-ray examinations. An example of a fuller but still partial coverage situation is the Michigan Blue plans. Here the subscriber must pay 10 percent of the charges for each service or $7.50 for each service whichever is greater, up to a maximum in any year of $75 for all such "professional" services.

Allowances or Fees for Specific Services

To set forth and compare for all of the contracts the allowances or fees paid for the multitude of surgical and other procedures would be neither feasible nor useful. However, the general level of payments to physicians can be indicated by the allowances paid for certain of the more common procedures or services. In table 3–4, data on allowances for a normal obstetrical delivery, nine surgical procedures, and in-hospital medical visits are set forth. It will be recalled that allowances are a credit against the doctor's charge in the case of plans providing indemnity benefits but in service or partial service plans must be accepted by a participating physician as full payment in the case of subscribers entitled to service benefits.

Most of these data were obtained from the *Blue Shield Manual*. The numerals following the names of obstetrical and surgical procedures are identification codes used by Blue Shield.

In the majority of cases the benefit for a normal delivery is in the form of an indemnity allowance. Allowances range from $50 to $157.50. Of the 41 contracts for which data are available, the allowance includes prenatal care in 26 plans and includes postnatal care in 28 plans.

Maternity allowances

Total contracts	72
Under $50	1
$50 to $59	6
$60 to $69	9
$70 to $79	20
$80 to $89	5
$90 to $99	10
$100 to $109	8
$110 or more	7
Usual, customary, reasonable, or prevailing charges	3
Allowance not specified	3

Eight of the contracts under study provide payment for physicians' surgical services and in-hospital medical visits on the basis of usual, customary, reasonable, or prevailing charges.[9]

[9] Only three of these contracts provide for payment for obstetrical delivery on this basis, however.

Since there are different shades of meaning associated with these terms, the codes used in table 3–4 to indicate this type of payment were not made uniform. Rather, they vary as do the terms used in the individual contracts. Payment of "usual, customary, and reasonable charges" is indicated in the contracts of the Madison (Wis.), Milwaukee (Wis.), North Dakota, and Richmond (Va.) plans. "Prevailing charges" are indicated in the Rockford (Ill.) and Kansas contracts. The contracts of the New Mexico and Hawaii plans specify payment of "usual charges."

The dollar allowances for specific surgical procedures as shown in the fee schedules of the individual contracts are given in table 3–4. The range and mean allowances for the nine procedures are given below. As indicated in the table dollar allowance data are not available in a number of cases. In some cases the plan fixes the fee or allowance on the basis of each case (complexities, time required, etc.) and thus no scheduled fee is quoted.

Allowances for surgical procedures

	Range	Mean
Colles fracture–0807	$35–$128	$74.51
Tonsillectomy and adenoidectomy, child–2992	25– 75	54.86
Gastrectomy–3115	150– 450	283.74
Appendectomy–3261	90– 215	140.51
Hemorrhoidectomy–3380	25– 180	108.00
Colecystectomy–3515	100– 300	210.70
Hernia, single, inguinal–3631	75– 185	131.56
Prostatectomy–4321	75– 400	243.28
Panhysterectomy–4617	150– 325	225.93

In comparing the fees paid by the various plans, it should be borne in mind that in the case of subscribers entitled to service benefits the payments represent the entire payment to the physician, whereas in other cases the fees allowed are in the nature of credits against the physician's charge.

The contracts commonly allow payment for in-hospital medical visits from the first day of hospitalization. Many contracts specify higher fees for the initial than for subsequent calls. First day

allowances, for example, range from $4 to $20, whereas second day allowances range from $4 to $12. Third and fourth day allowances range from $3 to $10 and $3 to $7, respectively. In a few cases, a range of allowances is specified; the plan determines the payment to be made on the basis of the nature of the case, time required, etc. For example, the Pennsylvania contract states payment of $20 or $30 the first day, $5, $7, or $10 for each subsequent day depending on the skill of the doctor and the time and effort expended. Other plans, at their discretion, increase regular allowances in cases of unusual severity. Of the eight contracts indicating payment of reasonable, customary, prevailing, or usual charges, the Hawaii contract allows only 80 percent of usual charges for all in-hospital medical care. Another variation is apparent in the Bremerton, Spokane, and Walla Walla contracts, which state that all necessary in-hospital medical care is paid for in full by the plan.

Physician visits in the office and home are covered under 11 contracts. Specific information on allowances is available for only a few of these. Hawaii pays 80 percent of usual charges; Spokane provides full payment of charges for office and home visits.

Payment to Nonparticipating Physicians

All of the service and service-indemnity plans and the majority of the indemnity plans provide benefits through participating physicians who have entered into agreement with the plan to serve its subscribers and to accept payment therefor from the plan. Several of the plans with participating physicians provide reduced benefits when the subscriber utilizes a nonparticipating physician. The reason for this, of course, is the belief that since participating physicians undertake certain obligations toward the plan it would be unfair to these physicians and would lessen inducements to participate if nonparticipating physicians were accorded the same rights and were paid the same fees. Some plans provide relatively more favorable benefits when the subscriber is served by a nonparticipating physician outside the plan's area than when he is served by a nonparticipating physician within the plan's area.

With regard to payments to nonparticipating physicians inside the plan's area, 47 contracts state that payment is on the same basis as to participating physicians—i.e., payment of the full schedule of allowances to the extent payable to participating physicians or usual, customary, reasonable, or prevailing charges. Among the remaining contracts, three specify payment of 50 percent of scheduled fees, five allow 75 percent, and two others 80 percent and 90 percent, respectively. A special schedule of allowances for nonparticipating physicians inside the plan area is applicable in three cases and in one case there is no payment to nonparticipating physicians in the plan's area. Eight of the indemnity plans do not have contracts with physicians and thus have no nonparticipating physicians. (Often payment for the services of nonparticipating physicians is made to the patient rather than to the doctor.)

Approximately two-thirds of the plans pay nonparticipating physicians outside the plan area on the same basis as participating physicians. Two allow 75 percent of the regular fee schedule and two others have a special schedule.

As indicated in the table, several plans state that they pay nonparticipating physicians in and outside the area only in the case of an accident or emergency illness. Whether this provision is closely adhered to in practice is not known.

Restrictions and Exclusions

Table 3–5 shows the provisions of the contracts with respect to waiting period for maternity benefits and the coverage or exclusion of certain specified conditions or illnesses. In most instances these follow the patterns described for companion Blue Cross programs.

As indicated below, all plans provide care for maternity only after the woman has been enrolled for a certain period of time—usually 9 or 10 months.

Maternity waiting period

Total contracts	72
7 months	1
8 months	4
9 months	52
10 months	13
11 months	1
Not specified	1

Treatment for mental illness is excluded under nine contracts and covered under 63 contracts—30 for the same number of days as for general illness, 33 for fewer days. Among the latter, benefit days ranged from 10 days during the lifetime of the subscriber to 70 days per admission (with any readmission within 6 months considered as a continuation of the former admission). The most common benefit period is 30 days during the contract year, the calendar year, or during any 12-month period. The Richmond, Va., contract requires a 12-month waiting period before care for mental illness is covered.

The provisions with regard to care of tuberculosis after diagnosis as such are generally similar. Thirty-one contracts cover treatment of this illness for the same number of days as for general illness and 25 for fewer days. Tuberculosis is not covered under 16 contracts. Under two of these contracts an exception to this exclusion is made in the case of surgical treatment of tuberculosis.

Alcoholism and drug addiction are covered by 52 of the plans under their most widely held contracts and not covered by 20 plans. Only 19 plans specify coverage of plastic surgery for cosmetic reasons. A few of the plans that do not regularly cover cosmetic surgery will do so if the need results from an accidental injury sustained while covered by the plan. Pre-existing conditions are covered after a waiting period—usually 9, 11, or 12 months—by 47 plans, covered without a waiting period by 22 plans, and not covered by three plans. Often the waiting periods or exclusions are waived for large enrolled groups or those meeting certain enrollment requirements. Benefits for venereal disease and sterilization are provided by 67 and 57 of the plans, respectively.

Fifty-six of the plans have waiting periods of 6 to 12 months for tonsil and adenoid operations. A number of the contracts have one or two other restrictions or exclusions. Common restrictions are waiting periods for treatment of hernia, hemorrhoids, varicose veins, and disorders of the genitalia. Several contracts exclude services for intentionally self-inflicted injuries. Some general exclusions include services for any condition for which coverage is available under a workmen's compensation act or similar legislation, whether or not the member claims compensation or receives benefits thereunder; services rendered in a Veterans Administration facility or Government hospital or services that are furnished in whole or in part under the laws of the United States or a political subdivision thereof; medical services where the hospital admission is primarily for medical observation or diagnostic studies: and regular care of the teeth, dental structures, and alveolar processes.

Age Limits for Dependent Children

As shown in table 3–6 and summarized below, the majority (46) of the plans, under their most widely held contract, cover newborn dependents from the date of birth for all contract benefits. Others have a waiting period before the newborn child is eligible to receive any benefits, and the remainder apply a waiting period only to the receipt of medical, i.e., nonsurgical services.

Total	72
Covered from birth for all contract benefits	46
Covered after waiting period for all benefits	20
Covered after waiting period for medical benefits	6

The applicable waiting periods are generally defined in terms of specified days, such as 14, 30, 45 days after birth, or in terms of the mother's discharge from the hospital. In several contracts, it is noted that age restrictions will not apply if the newborn child is prematurely delivered or has a congenital defect or serious birth injury.

All but three of the plans specify age 19 as the upper limit for coverage of unmarried dependent children. One contract specifies age 18 as the limit, another age 21. For one contract, information on the age limit was not available. Of the 69 plans with age 19 as the regular limit, six will also cover unmarried dependent children if they are full-time students—three up to age 23, one up to age 25, and two regardless of age. Another contract will extend its age limit to age 25 if the child is shown as a dependent on the subscriber's most recent

Federal individual income tax return.

Other exceptions to the age restrictions are made in cases of dependent children who are either mentally or physically handicapped and thus incapable of self support. Thirteen contracts cover dependents over the regular age limit who are incapable of self support—11 of these regardless of the dependent's age.

Conversion to Nongroup Contracts

No specific tabulation was made of the provisions in either Blue Cross or Blue Shield contracts relating to conversion privileges when a subscriber leaves employment. However, all Blue Cross and Blue Shield plans provide that a group subscriber on leaving his group may convert to a nongroup pay direct contract. Frequently, however, the benefits under this contract may be less than those under his former group coverage and the subscription rate, at least for equivalent benefits, is higher.

Blue Cross-Blue Shield Plan for Federal Employees

The "high option" of the Government-wide Service Benefit Plan offered jointly by the Blue Cross-Blue Shield plans to Federal employees under the Federal Employees Health Benefits Program is one of the broadest programs jointly offered by the plans to any large group of employees. Almost 4,000,000 Federal employees and their dependents are covered under this option. A summary of the benefits under this program may be helpful in appraising the benefits under the most widely held contracts here considered.

The plan, available at a total monthly cost in 1968 of $11.70 for the single employee and $26.78 for employee and family (including the Government contribution), provides basic hospital and surgical-medical benefits, maternity benefits, and supplemental benefits. Basic hospital benefits consist of hospital care in semiprivate accommodations for up to 365 days in each confinement (successive confinements are deemed to be continuous unless separated by at least 90 days). Hospital benefits include use of the operating room, drugs and medicines, laboratory and X-ray examinations, electrocardiograms and electroencephalograms, basal metabolism examinations, radiation therapy, physical therapy, anesthesia and oxygen and their administration, administration of (but not the cost of) blood and blood plasma, intravenous injections and solutions. If the member uses a private room, he receives a daily allowance equal to the hospital's average daily charge for semiprivate accommodations. In nonmember hospitals other than overseas, the plan gives an allowance of up to $12 per day toward room and board charges and 90 percent of charges for other covered hospital services. Overseas, the plan pays in full the hospital's usual charges for room and board and other covered services.

Outpatient hospital benefits include full payment for emergency care within 72 hours of an accident, use of operating room for outpatient surgery and all services rendered in connection with such use within 72 hours, and radiation therapy.

Basic surgical-medical benefits include surgery, anesthesia service, and radiation therapy; in-hospital medical care for up to 365 days in each hospital confinement; intensive medical care; consultations while hospitalized; and X-ray and laboratory examinations wherever performed. In areas designated as service areas (most of the United States) participating physicians accept the allowances paid by the plan as full payment for their services for subscribers with incomes under specified levels. In a considerable number of areas the plan pays physicians on the basis of usual and customary or prevailing charges, so physicians' charges are covered in full. In non-service areas, the applicable fee allowances need not be accepted by physicians as full payment.

All necessary hospital service is provided for maternity; for physician services the plan pays its applicable fee for delivery; no benefit is payable for prenatal or postnatal care.

Under supplemental benefits the plan pays 80 percent of reasonable and customary charges for covered services (to the extent such charges are not met by basic benefits) over and above a deductible of $100 for each covered person each

calendar year. Covered charges include charges of physicians for surgery, for home, office, and in-hospital visits, and charges for transfusions, ambulance service, physical therapy, orthopedic appliances, prescribed drugs and medicines, dental services required because of an accident, and private duty nursing care. (Visiting nurse service would be covered as a type of private duty nursing care by registered nurses.) Supplemental benefits will be paid up to a maximum of $50,000 for each subscriber.

All diseases and conditions without exception are covered. Cosmetic surgery is covered for accident cases. Routine or periodic physical examinations and immunizations are not covered. Benefits for mental illness or tuberculosis are the same as for general illness. Benefits for mental illness include day-night hospital care, group therapy, and services of a member of a "mental health team." The only important items of health care not covered in whole or in part are routine physical examinations, immunization shots, nursing-home care, and dental care (other than that required as a result of an accident).

It is apparent that this combined Blue Cross-Blue Shield program for Federal employees provides a coverage much superior to that provided by the most widely held contracts.[10]

Summary—Blue Cross and Blue Shield Coverage

It is apparent from this review that the benefits of the most widely held Blue Cross and Blue Shield contracts are largely focused on those associated with hospital inpatient care. Most plans or pairs of plans provide a fairly good coverage of hospital care for a special number of days, that is, they cover charges for semiprivate accommodations (or provide a room allowance that will pay most of such charges) and cover all or most of the charges for the special hospital services. Days of coverage vary widely. In virtually all cases the subscriber has some coverage of outpatient hospital care following accidents and of hospital charges for outpatient surgery. All of the plans or pairs of plans provide some coverage of surgery and obstetrics and all some coverage of inhospital medical visits. The coverage of care outside the hospital is noticeably meager. Less than half of the plans or pairs of plans provide basic coverage of X-ray and laboratory examinations for ambulatory patients (other than in accident cases) and in many cases the coverage provided is quite limited. Only a handful of plans provide any real basic coverage of physician service in the office and home. No coverage of outpatient drugs or appliances was found in the most widely held basic certificates and only two or three provide some coverage of visiting nurse service or nursing home care.[11] Benefits for preventive medicine or health maintenance services are lacking.

The great majority of the plans provide reduced coverage for mental illness or tuberculosis and any coverage of care in mental or tuberculosis hospitals is much restricted as compared with coverage in general hospitals.

A considerable number of diseases or conditions are excluded from coverage or covered only after the member has been enrolled for a certain period. Most of these are not of great importance from the standpoint of relative frequency of such cases. Nevertheless, such exclusion can be of considerable importance for those who happen to need care for these conditions. Of most importance is exclusion of care for pre-existing conditions during the first few months or year of membership, although this exclusion is frequently waived for large groups.

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[10] An indication of this superiority is provided by the fact that the 1967 subscription income per person covered under the Federal employee plan was $89.09, compared with $68.42 per person covered for hospital benefits under all Blue Cross-Blue Shield plans during the same year.

[11] In fairness it should be said that a few of the plans have riders or supplementary extended benefit or major medical contracts that provide coverage of care outside the hospital, and which are held by substantial numbers of their subscribers. Most plans offer these types of coverage, but data supplied by the two national associations indicate that the Blue plans do not currently insure a majority of their members for office and home calls, home nursing, X-ray and laboratory examinations, drugs, and other types of out-of-hospital health care.

TABLE 3–1.—Blue Shield plans: Subscription rates, type of benefits, income limits for service benefits, and Blue Cross affiliation

Region, State, and plan	Total enrollment, December 31, 1967 (in thousands)	Monthly subscription rate			Primary type of benefits	Income limits for service benefits			Blue Cross affiliation
		1 person	2 persons	Family		1 person	2 persons	Family	
New England	5,744								
Maine	347	$1.40	$2.80	$4.10	PS	$2,501		$4,001	Yes
New Hampshire-Vermont	410	NA	NA	4.25	I				Yes
Massachusetts	3,089	1.65		5.80	PS	5,000	$6,000	7,500	Yes
Rhode Island	683	[1] 1.95		[1] 6.35	PS	4,000		6,000	Yes
Connecticut	1,215	1.20	3.25	4.10	PS	3,500	4,500	5,500	Yes
Middle Atlantic	16,162								
New York:									
Albany	390	2.35	5.70	7.15	PS	6,000	6,000	6,000	Yes
Buffalo	865	3.15		8.30	PS	4,000		6,000	Yes
Jamestown	47	1.40	2.80	4.80	PS	6,000		6,000	Yes
New York City	5,385	1.68	4.48	5.88	PS	4,000		6,000	Yes
Rochester	726	1.92		5.50	PS	10,000		10,000	Yes
Syracuse	319	3.25		8.60	PS	6,000		6,000	Yes
Utica	278	2.50		7.25	PS	6,000		6,000	Yes
New Jersey	2,909	1.47	4.42	5.97	PS	5,000		7,500	Yes
Pennsylvania	5,244	1.88	4.37	6.07	PS	4,000	6,000	6,000	Yes
East North Central	13,886								
Ohio:									
Cleveland	1,195	3.60		7.20	PS	7,500		7,500	Yes
Columbus	2,856	1.40		3.60	I				Yes
Indiana	1,766	NA	NA	NA	I				Yes
Illinois:									
Chicago	2,271	1.50		4.58	I				Yes
Rockford	39	NA	NA	NA	S				Yes [2]
Michigan	4,321	3.67	9.04	10.88	PS	[3] 7,500		[3] 7,500	Yes
Wisconsin:									
Madison	473	2.14		7.05	S				No
Milwaukee	964	NA	NA	NA	S				Yes
West North Central	3,863								
Minnesota	628	3.81		9.75	PS	4,200		6,000	No
Iowa	800	2.40		6.65	PS	2,700		4,000	Yes
Missouri:									
Kansas City	433	2.90		7.35	PS	6,000		7,500	Yes
St. Louis	795	1.65		4.00	I				Yes
North Dakota	221	3.85	10.50	10.50	S				Yes
South Dakota	73	2.65		6.75	PS	3,000		4,000	Yes
Nebraska	262	4.15		9.35	PS	4,800		6,000	Yes
Kansas	653	3.80		9.26	S				Yes
South Atlantic	7,033								
Delaware	329	1.80	4.72	6.00	I				Yes
Maryland	991	1.80	4.86	6.30	PS	4,500		7,000	Yes
District of Columbia	1,104	3.12		9.86	PS	4,000		6,000	Yes
Virginia:									
Richmond	726	3.78		13.36	S				Yes
Roanoke	256	2.30		6.90	S				Yes

See codes and footnotes on next page.

TABLE 3–1.—Blue Shield plans: Subscription rates, type of benefits, income limits for service benefits, and Blue Cross affiliation—Continued

Region, State, and plan	Total enrollment, December 31, 1967 (in thousands)	Monthly subscription rate			Primary type of benefits	Income limits for service benefits			Blue Cross affiliation
		1 person	2 persons	Family		1 person	2 persons	Family	
South Atlantic—Con.									
West Virginia:									
Bluefield	22	$1.55		$5.20	PS	$5,000		$7,000	Yes
Charleston	95	1.35		4.00	PS	3,000		4,500	Yes
Clarksburg	18	2.25	$4.70	6.10	PS	3,000		4,500	No
Huntington	68	1.80		5.15	PS	3,000		4,000	Yes
Morgantown	19	1.10		2.70	PS	3,000		5,000	No
Parkersburg	39	1.40		6.05	PS	5,000		7,500	Yes
Wheelling	106	1.90		5.45	PS	4,000		5,000	Yes
North Carolina	1,275	1.40	[4] 2.80	3.90	PS	3,000		4,200	Yes
South Carolina	323	2.35		6.70	PS	3,600		6,000	Yes
Georgia:									
Atlanta	271	[5] 1.15		[5] 2.99	I				Yes
Columbus	321	1.60		4.45	PS	2,800		4,000	Yes
Florida	1,034	[6] 1.65		[6] 5.15	PS	3,000		4,000	Yes
East South Central	3,250								
Kentucky	953	1.10		2.20	I				Yes
Tennessee:									
Chattanooga	923	1.35		3.50	I				Yes
Memphis	124	NA	NA	NA	I				Yes
Alabama	814	[7] .65		2.75	I				Yes
Mississippi	437	NA	NA	NA	I				Yes
West South Central	2,833								
Arkansas	316	[8] 1.84		[8] 4.48	I				Yes
Oklahoma	537	NA	NA	NA	I				Yes
Texas	1,980	NA	NA	NA	I				Yes
Mountain	1,564								
Montana	92	NA	NA	NA	PS			7,500	No
Idaho	45	NA	NA	NA	S				No
Wyoming	84	3.30		6.60	PS	4,500		4,500	Yes
Colorado	720	[9] 3.70		[9] 7.40	PS	4,000		6,000	Yes
New Mexico	110	5.20		13.00	S				Yes
Arizona	235	2.66		9.04	PS	4,500		4,500	Yes
Utah	277	[7] 2.83	7.38	9.92	PS	6,000		8,000	Yes
Pacific	2,519								
Washington:									
Bremerton	41	[7] [10] 12.35	[10] 20.50	[10] 2.70	S				No
Seattle	283	NA	NA	NA	PS	9,000		9,000	No
Seattle (W.P.S.)	141	8.29		[10] 23.78	S				No
Spokane	108	NA	NA	NA	S				No
Tacoma	96	[7] [10] 7.95		[10] 19.70	PS	12,000		12,000	No
Walla Walla	9	[7] [10] 9.00	[10] 17.70	[10] 24.60	S				No
Wenatchee	20	NA	NA	NA	PS	15,000		15,000	No
Oregon	177	[10] 7.90	[10] 17.50	[10] 18.90	PS	8,000		8,000	No
California	1,307	NA	NA	NA	PS	7,500		7,500	No
Hawaii	366	[10] 7.66		[10] 21.48	S				No

NA Not available.
S Service.
PS Partial service.
I Indemnity.
[1] Rates for groups with 49 or fewer contracts. Larger groups individually experience rated.
[2] But not less than $5,000.
[3] Rate for parent and child.
[4] For groups of 25 or more.
[5] For groups of 5 to 49. Larger groups merit rated.
[6] For male subscribers. Higher rates for females.
[7] For groups of 2–9 employees. Larger groups experience rated.
[8] Groups of 25 or more are merit rated. Rates shown are for "Level 2" subscribers.
[9] Male subscriber, spouse and one child.
[10] Rate includes cost of hospital coverage.

TABLE 3–2.—Blue Shield plans: Services covered in and outside the hospital*

Region, State, and plan	Inpatient										
	Obstetrical	Surgery	Medical visits	Diagnostic X-ray	X-ray therapy	Radium therapy	Anesthesia	Pathology	Physical therapy	Electroshock	Consultation services
New England:											
Maine	X	X	X	X [1]	X [2]	X [2]	X				X
New Hampshire-Vermont	X	X	X	X [3]	X	X	X	X [4]			X [5]
Massachusetts	X	X	X	X [6]	X	X	X	X		X	
Rhode Island	X	X	X	X	X	X	X	X			
Connecticut	X [7]	X [7]	X								
Middle Atlantic:											
New York:											
Albany	X	X	X				X				X
Buffalo	X	X	X	X [10]	X	X	X				X
Jamestown	X	X		X			X [11]				
New York City	X	X	X	X [12]	X	X	X			X	X
Rochester	X	X	X		X	X	X				
Syracuse	X	X	X	X [14]	X	X	X	X [14]			X
Utica	X	X	X	X [15]	X [15]	X [15]	X				X [16]
New Jersey	X	X	X				X			X	X [5]
Pennsylvania	X	X	X		X [20]	X [20]					X [5]
East North Central:											
Ohio:											
Cleveland	X	X	X	X	X [22]	X [22]	X		X		
Columbus	X	X	X		X [23]	X [23]	X				
Indiana	X	X	X		X	X	X				
Illinois:											
Chicago	X	X	X	X [24]	X [25]	X [25]	X	X [24]		X	
Rockford	X	X	X	X [27]	X [27]	X [27]	X				X [27]
Michigan	X	X	X	X [28]	X [28]	X [28]	X	X [28]			X [28]
Wisconsin:											
Madison [29]	X	X	X	X	X	X	X				
Milwaukee [30]	X	X	X	X	X	X	X				X
West North Central:											
Minnesota	X	X	X		X	X	X			X	X [5]
Iowa	X	X	X	X	X [32]	X [32]	X	X			X
Missouri:											
Kansas City	X	X	X	X [33]	X	X	X				
St. Louis	X	X [34]	X	X [35]	X [36]	X [36]	X	X [36]	X		
North Dakota	X	X	X	X [37]	X	X	X	X [37]	X	X	X [5]
South Dakota	X	X [38]	X	X [39]	X	X	X	X [40]			
Nebraska	X	X	X	X	X [41]	X [41]	X	X		X	X [5]
Kansas	X [43]	X	X	X [42]	X	X	X	X			X [5]
South Atlantic:											
Delaware	X	X	X				X				X [44]
Maryland	X	X	X	X	X [46]	X [46]	X	X			X
District of Columbia	X	X	X	X [48]	X [48]	X [48]	X	X [48]		X	X
Virginia:											
Richmond	X	X	X	X	X	X	X	X			X
Roanoke	X	X	X	X	X		X				

See codes and footnotes at end of table.

TABLE 3–2.—Blue Shield plans: Services covered in and outside the hospital*—Continued

Region, State, and plan	Outpatient (physician's office or hospital outpatient department)								
	Surgery	Medical visits	Diagnostic X-ray	X-ray therapy	Radium therapy	Anesthesia	Pathology	Physical therapy	Electroshock
New England:									
Maine	X		X [1]	X [2]	X [2]	X			
New Hampshire-Vermont	X	X	X [3]	X	X	X	X [4]		
Massachusetts	X		X [6]	X	X	X			X
Rhode Island	X		X	X		X	X		
Connecticut	X [7]		X [8]						
Middle Atlantic:									
New York:									
Albany	X		X [9]			X			
Buffalo	X		X [10]	X	X	X			
Jamestown	X		X			X [11]			
New York City	X [13]		X [12]	X [13]	X [13]	X [13]			X
Rochester	X			X	X	X			
Syracuse	X		X [14]	X	X	X	X [14]		
Utica	X		X [16]	X [15]	X [15]		X [17]		
New Jersey	X [18]					X [19]			
Pennsylvania	X	X [21]		X [20]	X [20]				
East North Central:									
Ohio:									
Cleveland	X		X	X [22]		X		X	
Columbus	X			X [23]	X [23]	X			
Indiana	X			X	X				
Illinois:									
Chicago	X		X [24]	X [25]	X [25]	X	X [24]		
Rockford	X		X [27]	X [27]	X [27]	X	X [27]		
Michigan	X		X [28]	X [28]	X [28]	X	X [28]		
Wisconsin:									
Madison [29]	X		X	X	X	X			
Milwaukee [30]	X		X	X	X				
West North Central:									
Minnesota	X		X [31]	X	X	X	X [31]		
Iowa	X		X	X [32]	X [32]	X	X		
Missouri:									
Kansas City	X		X [33]	X	X	X			
St. Louis	X [34]		X [35]	X [36]		X			
North Dakota	X		X [37]	X	X	X	X [37]		X
South Dakota	X [38]		X [39]	X	X	X	X [40]		
Nebraska	X		X [42]	X [41]	X [41]	X	X		
Kansas	X		X [42]	X	X	X			
South Atlantic:									
Delaware	X		X [45]			X			
Maryland	X		X [47]	X [46]	X [46]		X [47]		
District of Columbia	X		X [48]	X [48]	X [48]	X	X [48]		X
Virginia:									
Richmond	X		X [49]	X	X	X	X		
Roanoke	X			X		X			

See codes and footnotes at end of table.

TABLE 3-2.—Blue Shield plans: Services covered in and outside the hospital*—Continued

Region, State, and plan	Inpatient										
	Obstetrical	Surgery	Medical visits	Diagnostic X-ray	X-ray therapy	Radium therapy	Anesthesia	Pathology	Physical therapy	Electroshock	Consultation services
South Atlantic—Con.											
West Virginia:											
Bluefield	X	X	X	X	X	X	X	X			
Charleston	X	X	X		X	X	X				X [5]
Clarksburg	X	X	X		X [50]	X [50]	X				X [16]
Huntington	X	X	X		X [52]	X [53]	X				
Morgantown	X	X	X	X			X				
Parkersburg	X	X	X		X	X	X				X
Wheeling	X	X	X	X [54]			X				X [5]
North Carolina	X	X	X	X [55]	X [56]	X [57]	X	X	X		
South Carolina	X	X	(58)	(58)	(58)	(58)	(58)	(58)			
Georgia:											
Atlanta	X	X		X			X [59]	X			
Columbus	X	X	X	X	X [61]	X [61]	X				
Florida	X	X	X	X	X [62]	X	X [63]	X	X	X	
East South Central:											
Kentucky	X	X	X [64]	X [65]	X [66]	X [67]	X				
Tennessee:											
Chattanooga	X	X	X	X [68]			X				
Memphis [26]	X	X	X				X				
Alabama	X	X	X	X			X	X			
Mississippi [26]	X	X	X								
West South Central:											
Arkansas [26]	X	X	X	X [70]	X	X	X				
Oklahoma	X	X	X	X [71]	X [72]	X [72]	X	X [73]			
Texas	X	X	X	X [74]	X [75]	X [75]	X	X [74]	X		
Mountain:											
Montana [26]	X	X	X		X [76]	X [76]	X	X			X
Idaho [26]	X	X	X		X	X	X		X		X
Wyoming	X	X	X	X [77]	X [78]	X [78]	X	X			X [5]
Colorado	X	X	X	X [79]	X	X	X	X [80]			X [5]
New Mexico	X	X	X	X	X	X	X	X			X
Arizona	X	X	X		X	X	X				X [5]
Utah	X	X	X	X [81]			X			X	X [5]
Pacific:											
Washington:											
Bremerton [26]	X	X	X	X [82]	X	X	X	X [83]			X
Seattle	X	X	X	X	X	X [84]	X [84]	X			X
Seattle (WPS) [26]	X	X	X	X [86]	X [87]	X	X	X [86]	X	X	X
Spokane [26]	X	X	X		X	X	X		X		X
Tacoma [26 90]	X	X	X	X	X	X	X	X	X	X	X
Walla Walla [26]	X	X	X	X [91]	X [92]	X [92]	X	X [91]			X
Wenatchee	X	X	X	X	X	X	X		X [93]		
Oregon [26]	X	X	X		X		X		X		X
California [26]	X [94]	X	X	X [95]	X	X	X	X [95]			X
Hawaii [26]	X	X	X [97]	X [98]	X [99]	X [99]	X	X		X	X

See codes and footnotes at end of table.

TABLE 3-2.—Blue Shield plans: Services covered in and outside the hospital*—Continued

Region, State, and plan	Outpatient (physician's office or hospital outpatient department)								
	Surgery	Medical visits	Diagnostic X-ray	X-ray therapy	Radium therapy	Anesthesia	Pathology	Physical therapy	Electroshock
South Atlantic—Con.									
West Virginia:									
Bluefield	X			X [10]	X [10]	X [10]	X		
Charleston	X			X	X	X			
Clarksburg	X		X [51]	X [50]	X [50]				
Huntington	X			X [52]	X [52]				
Morgantown	X [53]					X [53]			
Parkersburg	X			X	X	X			
Wheeling	X		X [54]	X	X	X			
North Carolina	X		X [55]	X [56]	X [57]	X	X		
South Carolina	X		([58])	([58])	([58])	([58])	([58])		
Georgia:									
Atlanta	X		X [60]			X [59]			
Columbus	X		X [42]	X [61]	X [61]		X		
Florida	X		X [42]	X [62]	X	X [63]			X
East South Central:									
Kentucky	X		X [65]	X [66]	X [67]	X			
Tennessee:									
Chattanooga	X					X			
Memphis [26]	X								
Alabama	X		X [69]			X			
Mississippi [26]	X								
West South Central:									
Arkansas [26]	X		X [70]	X	X	X			
Oklahoma	X		X [71]	X [72]	X [72]	X	X [73]		
Texas	X		X [74]	X [75]	X [76]	X	X [74]	X	
Mountain:									
Montana [20]	X		X [42]	X [76]	X [76]	X			
Idaho [26]	X	X	X	X	X	X	X	X	
Wyoming	X		X [77]	X [78]	X [78]	X	X		X [19]
Colorado	X		X [79]	X	X	X	X [80]		
New Mexico	X		X	X	X	X	X		
Arizona	X			X	X	X			
Utah	X		X [81]			X			
Pacific:									
Washington:									
Bremerton [26]	X	X [83]	X [82]	X	X	X	X [82]		
Seattle	X	X [85]	X	X [84]	X [84]	X	X		
Seattle (WPS) [20]	X	X [88]	X [86]	X [87]	X	X	X [86]	X	X
Spokane [26]	X [89]	X [85]	X [82]	X	X	X [19]	X [82]	X	
Tacoma [26 90]	X	X	X	X	X	X	X	X	X
Walla Walla [26]	X		X [91]	X [92]	X [92]	X	X [91]		
Wenatchee	X	X [85]	X	X	X	X		X [93]	
Oregon [26]	X	X		X		X		X	
California [26]	X		X [96]	X	X	X	X [96]		
Hawaii [26]	X	X [97]	X [98]	X [99]	X [99]	X	X		X

See codes and footnotes on next page.

TABLE 3–2.—Blue Shield plans: Services covered in and outside the hospital*—Continued

*Benefits described herein are exclusive of those under major medical, catastrophic illness or related riders which in a few cases are also "most widely held" in addition to basic certificates. Such cases include: (1) Mass.—master medical certificate, (2) N.J.—extended outpatient hospital benefit rider, (3) Pa.—additional medical coverage agreement, (4) Del.—extended benefit rider, (5) Ark.—catastrophic illness endorsement, (6) Spokane, Wash.—major medical endorsement, and (7) Hawaii—major medical expense.

[1] Within 72 hours of an accident or when required within 60 days of the provision of related covered services. If not related, a $7.50 deductible is applicable each 31-day period. Diagnostic services not to exceed $25 in any 12-month period.

[2] Only when such therapy is in lieu of surgery or within 12 months of surgery for a directly related condition.

[3] Up to $60 for X-ray services after the application each contract year of a $10 deductible. The deductible will not apply in cases of accidental injury when treated within 24 hours after an accident.

[4] An allowance each contract year of $40 after the application each contract year of a $10 deductible.

[5] Limited to one per admission.

[6] Pays full schedule for endoscopic and accidental cases. Pays 50 percent of the scheduled allowances in other cases after a deductible of $15.

[7] Maximum payment per member of $2,100 per calendar year for all surgical and obstetrical procedures.

[8] In office only; maximum of $110 during any calendar year; deductible of $10 for each procedure.

[9] Plan pays 80 percent of scheduled fee for service benefit members. Benefit limited to $60 during year for indemnity members.

[10] Maximum $70 per certificate year.

[11] Maximum $25 per contract year.

[12] Payment for all X-ray examinations (inpatient and outpatient) limited to maximum of $150 per year. A $20 deductible applies each 2 weeks.

[13] Excludes care in hospital outpatient department.

[14] Plan pays 50 percent of schedule allowances.

[15] Plan pays 50 percent of schedule up to a maximum of $100 per certificate year.

[16] Limited to 3 per contract year.

[17] In hospital outpatient department only. Laboratory services—maximum $10 per certificate year; EKG—maximum $30 per certificate year; BMR—maximum $5 per certificate year.

[18] For normal surgery, covered in hospital outpatient department only. Emergency service outside hospital within 48 hours after an accident.

[19] In outpatient department only.

[20] When performed within 90 days of definitive surgery for the same condition; payment begins with fourth treatment.

[21] Office and home visits only and only for employed subscriber unable to work. Benefits begin with fourth visit, up to 21 visits during year.

[22] Maximum of $500 per year.

[23] Covers neoplastic disease only; X-ray therapy—maximum of 30 treatments; radium therapy—maximum $150 per contract year.

[24] Maximum $20 per member per 90-day period. Outpatient benefits in emergency cases only.

[25] Maximum $200 per year for all radiotherapy.

[26] This most widely held contract also covers hospitalization benefits.

[27] The member shall pay a $5 deductible for each service up to a maximum of $75 per year.

[28] Subject to contribution by member of $5 or 10 percent of scheduled fee, whichever is greater, for each service. Maximum contribution per member for any given 12-month period is $75. Consultations limited to one during each period of continuous hospitalization.

[29] The maximum aggregate liability of Blue Shield for any 1 period of illness per participant is $1,000. Any 1 period of illness shall be deemed to have terminated if the subscriber resumes all the duties of his occupation on a full-time basis or if a dependent resumes in full his normal activities.

[30] Maximum liability of plan is $1,000, or $10,000, or unlimited per period of illness.

[31] Maximum of $90 per certificate year.

[32] Aggregate maximum of $300 per condition.

[33] Covers accident cases only. Maximum benefit $35 per accident.

[34] Maximum allowance of $200 per contract year for any one condition.

[35] Maximum $25 per certificate year. Covered in outpatient department or doctor's office only in accident cases.

[36] Maximum $100 per certificate year. $10 maximum per certificate year for pathological examinations.

[37] X-ray and pathology examinations must be followed within 30 days by covered surgery or in-hospital medical care. Otherwise there is a $10 deductible beginning with day of first service in each successive 7-day period.

[38] Maximum aggregate liability of plan of $5,000 for all surgical services in member's lifetime.

[39] If rendered within 30 days prior to or following surgical services. Maximum $25 per condition.

[40] Maximum $15 per condition.

[41] Maximum $600 per member per year.

[42] For emergency or accident cases only.

[43] Covers complications and accidents of pregnancy. Does not include delivery as part of basic plan. Normal delivery covered under endorsement.

[44] Up to 2 consultations per confinement.

[45] Maximum $50 per year.

[46] Maximum $200 per condition.

[47] Benefits for diagnostic X-ray, laboratory, and pathology examinations are provided when such are required as a result of an accident and are performed in the outpatient department of a hospital within 72 hours of the accident or when such examinations are required within 72 hours of related surgery.

[48] Plan pays 75 percent of scheduled allowances.

[49] When rendered within 30 days before admission of cases covered under contract or for accident cases not needing hospitalization.

[50] Maximum $300 per certificate year.

[51] Maximum $75 per condition.

[52] X-ray therapy, maximum $150 per certificate year; radium therapy, maximum $250 per certificate year. Outpatient benefits in doctor's office only.

[53] If services rendered within 24 hours of accident or injury.

[54] 80–20 coinsurance. Maximum $75 per year.

[55] Plan pays 80 percent of listed allowances. For accidental injury up to $10 indemnity allowance when made within 72 hours of injury.

[56] Deep X-ray up to $225 per 12 months. Superficial up to $50 per 12 months.

[57] Radium, $75 per 12 months; isotope therapy, $125 per 12 months.

[58] Available as endorsements and partial service when included.

[59] Pays 80 percent of physician's reasonable charge.

[60] If rendered within 24 hours of an accident.

[61] Maximum $80 or $100 according to specific diagnosis.

[62] Maximum $333.

[63] Maximum $200 per hospital confinement. Outpatient services available only in outpatient department of hospital.

[64] Covered by rider; benefits begin on fourth day of hospitalization.

[65] Only when rendered within 30 days of accident. Maximum $15 per accident or certificate year.

[66] Treatment of malignant conditions only and only when such treatment is in lieu of surgery. Treatment of skin cancer—maximum $25 per certificate year; major malignant growths—maximum $150 per certificate year.

[67] Maximum $50 per certificate year.

[68] Pays for interpretation when hospital and physician bill separately and when Blue Cross covers hospital's charge for X-ray. Maximum $75.

[69] In hospital outpatient department only within 48 hours of accidental injury.

[70] In accident cases only when rendered within 7 days of accident. Maximum $15.

[71] Accident cases only within 45 days of accident; maximum $40 for any one accident.

[72] For treatment of malignancies only. Maximum $200 per complete course of treatment for major cancer conditions.

[73] Microscopic tissue examinations maximum $10.

[74] Maximum $50 during contract year.

[75] Maximum $300 per contract year.

[76] Maximum $225–315.

[77] Within 30 days of related surgery or 7 days of related accident. Also most widely held is diagnostic X-ray and laboratory supplement which has a $10 deductible.

[78] Maximum $300 for any one condition.

[79] When rendered within 30 days of related surgery or 7 days of an accident. Maximum $50 per member per contract year.

[80] When rendered in connection with and within 30 days of surgery. Maximum $50 per member per contract year.

[81] Maximum $15 per calendar year.

[82] Full benefits for subscriber; partial or defined benefits for dependents.

[83] For subscriber member only. Up to 35 such visits per certificate year.

[84] Benefits available after 6-month membership.

[85] For subscriber, limited to 35 such visits per calendar year. Other members are entitled to outpatient medical care only in situations defined by plan.

[86] Maximum $100 per certificate year.

[87] Maximum $250.

[88] Member pays $1.50 for home, office and outpatient visits. Limited to a total of 35 visits per membership year.

[89] For dependents, outpatient surgery only if treatment begins 72 hours after accidental injury.

[90] Plan covers all necessary professional services. Limited to a period of 1 year for any 1 injury or condition beginning with date of first call or treatment.

[91] Maximum $50 per 12-month period for diagnostic X-ray and laboratory examinations; $50 per accident for X-rays in fracture or suspected fracture cases; within 72 hours of accident for emergency X-rays.

[92] Maximum $250.

[93] When performed by a participating physician only.

[94] Any services with respect to pregnancy are confined to ectopic (tubal or extra-uterine) pregnancy, preclampsia, eclampsia, pernicious vomiting, and toxemia of pregnancy with vomiting. Normal delivery covered under endorsement.

[95] Plan pays 80 percent of costs.

[96] For X-ray and pathology combined, maximum $50 per calendar year.

[97] Plan pays 80 percent of usual and customary charges.

[98] Plan pays 50 percent of charges.

[99] Plan pays 80 percent of charges for treatment of malignancies.

TABLE 3–3.—Blue Cross and Blue Shield coverage of inpatient X-ray and laboratory examinations

Region, State, and plan	Inpatient X-ray examinations			Inpatient laboratory exmaiuations		
	Blue Cross	Blue Shield	Both BC–BS, full or partial coverage	Blue Cross	Blue Shield	Both BC–BS, full or partial coverage
New England:						
Maine BC–BS coordinated	X [1]	X [2]	P	X [1]	----------	P
New Hampshire-Vermont BC–BS coordinated	X [3]	X [4]	P	X	----------	F
Massachusetts BC–BS coordinated	X	X [5]	F	X	X	F
Rhode Island BC–BS coordinated	X [6]	X [7]	F	X [6]	X	F
Connecticut BC–BS coordinated	X	----------	F	X	----------	F
Middle Atlantic:						
New York:						
Albany BC–BS coordinated	X	----------	F	X	----------	F
Buffalo BC–BS coordinated	----------	X [8]	P	X	----------	F
Jamestown BC–BS coordinated	X [9]	X	F	X [9]	----------	F
New York City BC–BS coordinated	X	X [10]	F	X	----------	F
Rochester BC–BS coordinated	X [9]	----------	F	X [9]	----------	F
Syracuse BC–BS coordinated	----------	X [11]	P	X	X [11]	F
Utica BC–BS coordinated	----------	X [12]	P	X	----------	F
Watertowu BC and Utica BS coordinatod	----------	X [12]	P	X	----------	F
New Jersey BC–BS coordinated	X	----------	F	X	----------	F
Pennsylvania:						
Allentown BC and Pa. BS coordinated	X	----------	F	X	----------	F
Harrisburg BC and Pa. BS coordinated	X [9]	----------	F	X [9]	----------	F
Philadelphia BC and Pa. BS coordinated	X [9]	----------	F	X [9]	----------	F
Pittsburgh BC and Pa. BS coordinated	X	----------	F	X	----------	F
Wilkes-Barre BC aud Pa. BS coordinated	X	----------	F	X	----------	F
East North Central:						
Ohio:						
Canton BC and Ohio BS coordinated	X	----------	F	X	----------	F
Cincinnati BC and Ohio BS coordinated	X	----------	F	X	----------	F
Cleveland BC and Cleveland BS coordinated	X	X	F	X	----------	F
Columbus BC and Ohio BS coordinated	X	----------	F	X	----------	F
Lima BC and Ohio BS coordinated	X	----------	F	X	----------	F
Toledo BC and Ohio BS coordinated	X	----------	F	X	----------	F
Youngstown BC and Ohio BS coordinated	X [13]	----------	F	X [13]	----------	F
Indiana BC–BS corrdinated	X	----------	F	X	----------	F
Illinois:						
Chicago BC–BS coordinated	X [9]	X [14]	F	X [9]	X [14]	F
Rockford BC–No BS coordination	----------	(a)	(15)	X	(a)	F
Rockford BS and Chicago BC coordinated	X [9]	X [16]	P	X [9]	----------	F
Michigau BC–BS coordinated	----------	X [17]	P	X	X [17]	F
Wisconsin:						
Madison BS–No BC coordination	(b)	X [18]	F	(b)	----------	(19)
Milwaukee BC–BS coordinated	X [9]	X [20]	F	X [9]	----------	F
West North Central:						
Minuesota BC–No BS coordination	X [9]	(a)	F	X [9]	(a)	F
Minnesota BS–No BC coordination	(b)	----------	(19)	(b)	----------	(19)
Iowa:						
Des Moines BC and Iowa BS coordinated	(21)	X	F	(21)	X	F
Sioux City BC and Iowa BS coordiuated	----------	X	F	----------	X	F
Missouri:						
Kansas City BC–BS coordinated	X	X [22]	F	X	----------	F
St. Louis BC–BS coordinated	----------	X [23]	P	X	X [24]	F
North Dakota BC–BS coordinated	X [9]	X [25]	F	X [9]	X [25]	F
South Dakota BS and Sioux City, Iowa, BC coordinated	----------	X [26]	P	----------	X [27]	P
Nebraska BC–BS coordinated	----------	X	F	----------	X	F
Kansas BC–BS coordinated	X [28]	X [29]	P	X	X	F
South Atlantic:						
Delaware BC–BS joint plans	X [30]	----------	P	X	----------	F
Maryland BC–BS coordinated	X	X	F	X	X	F
District of Columbia BC–BS coordinated	----------	X [31]	P	----------	X [31]	P
Virginia:						
Richmond BC–BS coordinated	----------	X	F	X	X	F
Roanoke BC–BS coordinated	X [32]	X	F	X	----------	F

See codes and footnotes at end of table.

TABLE 3–3.—Blue Cross and Blue Shield coverage of inpatient X-ray and laboratory examinations—Continued

Region, State, and plan	Inpatient X-ray examinations			Inpatient laboratory examinations		
	Blue Cross	Blue Shield	Both BC-BS, full or partial coverage	Blue Cross	Blue Shield	Both BC-BS, full or partial coverage
South Atlantic—Con.						
West Virginia:						
Bluefield BC-BS coordinated	X	X	F	X	X	F
Charleston BC BS coordinated	X	----	F	X	----	F
Clarksburg BS-No BC coordination	(c)	----	(19)	(c)	----	(19)
Huntington BS and Charleston BC coordinated	X	----	F	X	----	F
Morgantown BS-No BC coordination	(c)	X	F	(c)	----	(19)
Parkersburg BC-BS coordinated	X	----	F	X	----	F
Wheeling BC-BS coordinated	X	X [33]	F	X	----	F
North Carolina:						
Chapel Hill BC-BS joint plans [34]	X	X [35]	F	X	X	F
Durham BC-BS joint plans [34]	X	X [35]		X	X	F
South Carolina BC-BS coordinated	X [9]	(36)	F	X [9]	(36)	F
Georgia:						
Atlanta BC-BS coordinated	X [37]	X	F	X [37]	X	F
Columbus BC-BS coordinated	X [38]	X	F	X	----	F
Florida BC-BS coordinated	X	X	F	X [39]	X	F
East South Central:						
Kentucky BC-BS coordinated	X	X [40]	F	X	----	F
Tennessee:						
Chattanooga BC-BS joint plans	X	X [41]	F	X	----	F
Memphis BC-BS joint plans	X [42]	----	P	X [42]	----	P
Alabama BC-BS joint plans	X [9]	X	F	X [9]	X	F
Mississippi BC-BS joint plans	X	----	F	X	----	F
West South Central:						
Arkansas BC-BS joint plans	X [43]	X [44]	F	X [43]	----	F
Louisiana:						
Baton Rouge BC-No BS plan	X	(a)	F	X	(a)	F
New Orleans BC-No BS plan	X	(a)	F	X	(a)	F
Oklahoma BC-BS coordinated	X	X [45]	F	X	X [45]	F
Texas BC-BS coordinated	X	X [47]	F	X	X [47]	F
Mountain:						
Montana BC-No BS coordination	X	(a)	F	X	(a)	F
Montana BS-No BC coordination	(b)	----	F	(b)	X	F
Idaho BC-No BS coordination	X	(a)	F	X	(a)	F
Idaho BS-No BC coordination	(b)	----	F	(b)	----	F
Wyoming BC-BS coordinated	X	X [48]	F	X	X	F
Colorado BC-BS coordinated	X	X [49]	F	X	X [50]	F
New Mexico BC-BS coordinated	X [9]	X	F	X [9]	X	F
Arizona BC-BS coordinated	X	----	F	X	----	F
Utah BC-BS coordinated	X	X [51]	F	X	----	F
Pacific:						
Washington:						
Washington BC-No BS coordination	X [9]	(a)	F	X [9]	(a)	F
Bremerton BS-No BC coordination	(b)	X [53]	F	(b)	X [53]	F
Seattle (KCM) BS-No BC coordination	(b)	X	F	(b)	X	F
Seattle (WPS) BS-No BC coordination	(b)	X [54]	P	(b)	X [54]	P
Spokane BS-No BC coordination	(b)	----	P	(b)	----	P
Tacoma BS-No BC coordination	(b)	X	F	(b)	X	F
Walla-Walla BS-No BC coordination	(b)	X [55]	P	(b)	X [55]	P
Wenatchee BS-No BC coordination	(52)	X	F	(52)	----	F
Oregon BC-No BS coordination	X	(a)	F	X	(a)	F
Oregon BS-No BC coordination	(b)	----	P	(b)	----	P
California:						
Los Angeles BC-No BS coordination	X	(a)	F	X	(a)	F
Oakland BC-No BS coordination	X	(a)	F	X	(a)	F
San Francisco BS-No BC coordination	(b)	X [56]	P	(b)	X [56]	P
Hawaii BS-No BC plan	(b)	X [57]	P	(b)	X [57]	P

See codes and footnotes on next page.

TABLE 3–3.—Blue Cross and Blue Shield coverage of inpatient X-ray and laboratory examinations—Continued

(a) Blue Cross writes own surgical-medical contracts.
(b) Blue Shield writes own hospitalization contracts.
(c) Associated with organization (not Blue Cross) which writes hospitalization contracts.
F Full coverage.
P Partial (or limited) coverage.

[1] An allowance equal to 50 percent of the first $70 of expense incurred for diagnostic services, plus 100 percent of the expenses for such services in excess of $70. Diagnostic services include but are not limited to X-ray examinations, laboratory examinations, use of cardiographic equipment, basal metabolism tests.
[2] Within 72 hours of an accident or related within 60 days to other covered services. If not related a $7.50 deductible is applicable each 31-day period. Diagnostic services not to exceed $25 in any 12-month period.
[3] Up to $25 per admission.
[4] Up to $60 for X-ray services after the application each contract year of a $10 deductible. The deductible will not apply in cases of accidental injury when treated within 24 hours after an accident.
[5] Pays full schedule for endoscopic and accidental cases. Pays 50 percent of the scheduled allowances in other cases after a deductible of $15.
[6] The full amount of hospital's usual charges for the "hospital component" of services.
[7] Blue Shield covers professional component.
[8] Maximum $70 per certificate year.
[9] When provided and billed for as a regular hospital service or when customarily furnished by the hospital.
[10] Payment for all X-ray examinations (in and outpatient) limited to maximum of $150 per year. A $20 deductible applies each two weeks.
[11] Plan pays 50 percent of scheduled allowances.
[12] Plan pays 50 percent of schedule up to a maximum of $100 per certificate year.
[13] When provided by member hospitals and performed by hospital employee.
[14] Maximum $20 per member per 90-day period.
[15] Degree of coverage cannot be determined since no details are available on X-ray and laboratory services provided under the Blue Cross surgical-medical contract.
[16] The member shall pay a $5 deductible for this and certain other services up to a maximum of $75 per year.
[17] Subject to contribution by member of $5 or 10 percent of scheduled fee, whichever is greater for these and certain other services. Maximum contribution per member for any given 12-month period is $75.
[18] Subject to maximum aggregate liability of Blue Shield of $1,000 per participant for any one period of illness.
[19] Degree of coverage cannot be determined since no details are available on X-ray and laboratory services provided under the Blue Shield hospitalization contract.
[20] Subject to maximum liability of plan of $1,000, $10,000, or unlimited per period of illness.
[21] X-ray and laboratory coverage is sold to Blue Cross only subscribers under a special certificate issued by Blue Shield.
[22] Covers accident cases only. Maximum benefit $35 per accident.
[23] Maximum $25 per certificate year.
[24] Maximum $10 per certificate year.
[25] X-ray and pathology examinations must be followed within 30 days by covered surgery or in-hospital medical care. Otherwise, there is a $10 deductible beginning with day of first service in each successive 7-day period.
[26] If rendered within 30 days prior to or following surgical services. Maximum $25 per condition.
[27] Maximum $15 per condition.
[28] Only for diagnostic accident X-rays; excludes nonaccident diagnostic X-rays.
[29] For emergency or accident cases only.
[30] Plan pays 80 percent of charges. Excludes chest X-rays provided as routine part of hospital admission.
[31] Plan pays 75 percent of scheduled allowances.
[32] Up to $15 per admission.
[33] 80–20 coinsurance. Maximum $75 per year.
[34] Chapel Hill and Durham plans merged January 1, 1968.
[35] 80 percent of listed allowances. For accidental injury up to $10 indemnity allowance when made within 72 hours of injury.
[36] Available as endorsements and partial services when included.
[37] When rendered as a regular hospital service customarily provided by the hospital and when service is billed for and payable to the hospital and is performed by a hospital employee.
[38] 50 percent of hospital's charge.
[39] Not including section examinations and pathological examinations.
[40] Only when rendered within 30 days of an accident. Maximum $15 per accident or certificate year.
[41] Pays for interpretation when hospital and physician bill separately and when Blue Cross covers hospital's charge for X-ray. Maximum $75.
[42] Plan pays 80 percent of hospital charges when services rendered by hospital employee.
[43] When administered by a full-time employee of hospital who is not compensated by a percentage of fees or other commission arrangement.
[44] In accident cases only when rendered within 7 days of accident. Maximum $15.
[45] Accident cases only within 45 days of accident; maximum $40 for any one accident.
[46] Microscopic tissue examinations maximum $10.
[47] Maximum $50 during contract year.
[48] Within 30 days of related surgery or 7 days of related accident.
[49] When rendered within 30 days of related surgery or 7 days of an accident. Maximum $50 per contract year.
[50] When rendered in connection with and within 30 days of surgery. Maximum $50 per contract year.
[51] Maximum $15 per calendar year.
[52] For most group business in the Wenatchee area, coverage is coordinated with Washington Blue Cross.
[53] Full benefits for subscriber, partial or defined benefits for dependents.
[54] Maximum $100 per certificate year.
[55] Maximum $50 per 12-month period for diagnostic X-ray and laboratory examinations; $50 per accident for X-rays in fracture or suspected fracture cases; within 72 hours of accident for emergency X-rays.
[56] Plan pays 80 percent of costs.
[57] Plan pays 50 percent of charges.

TABLE 3–4.—Blue Shield plans: Allowances for specific services

Region and State	Obstetrical			Surgery								
	Normal delivery (4821)	Covers— Pre-natal care	Covers— Post-natal care	Fracture colles (0807)	Tonsillectomy and adenoidectomy, child (2992)	Gastrectomy (3115)	Appendectomy (3261)	Hemorrhoidectomy (3380)	Colecystectomy (3515)	Hernia (3631)	Prostatectomy (4321)	Panhysterectomy (4617)
New England:												
Maine	$62.50	C[2]	C[2]	$37.50	$35.00	$200.00	$100.00	$75.00	$137.50	$100.00	$175.00	$150.00
New Hampshire-Vermont	65.00	C	C	55.00	40.00	215.00	110.00	80.00	160.00	100.00	185.00	175.00
Massachusetts	75.00	NS	NS	75.00	50.00	300.00	125.00	100.00	225.00	125.00	200.00	225.00
Rhode Island	90.00	C[2]	C[2]	75.00	58.00	334.00	150.00	113.00	225.00	150.00	259.00	250.00
Connecticut	75.00	NC	C	75.00	50.00	NS	135.00	95.00	205.00	135.00	225.00	225.00
Middle Atlantic:												
New York:												
Albany	75.00	NS	NS	90.00	60.00	288.00	150.00	IC	216.00	150.00	288.00	240.00
Buffalo	80.00	NS	NS	85.00	75.00	350.00	150.00	150.00	225.00	125.00	125.00–300.00	250.00
Jamestown	115.00	C	C	100.00	55.00	225.00	125.00	100.00	175.00	125.00	225.00	225.00
New York City	75.00	C	C	100.00	65.00	350.00	175.00	120.00	225.00	150.00	300.00	275.00
Rochester	75.00	C	C	100.00	75.00	400.00	175.00	150.00–175.00	275.00	165.00	365.00	300.00
Syracuse	75.00	C	C	74.00	57.00	291.00	148.00	109.00	221.00	139.00	250.00	238.00
Utica	75.00	NS	NS	80.00	50.00	300.00	150.00	IC	225.00	150.00	200.00	200.00
New Jersey	150.00	C	C	60.00	65.00	350.00	175.00	125.00	250.00	150.00	300.00	275.00
Pennsylvania	90.00	C[2]	C[2]	75.00	60.00	360.00	150.00	135.00	270.00	150.00	270.00	250.00
East North Central:												
Ohio:												
Cleveland	60.00	NS	NS	100.00	75.00	350.00	165.00	IC	250.00	150.00	350.00	300.00
Columbus	50.00	NS	NS	50.00	40.00	300.00	125.00	115.00–130.00	175.00	100.00	200.00	175.00
Indiana	100.00	NS	NS	100.00	60.00	250.00	150.00	25.00–125.00	250.00	150.00	200.00	250.00
Illinois:												
Chicago	80.00	C	C	65.00	45.00	235.00	125.00	85.00	165.00	100.00	165.00	200.00
Rockford	PC	NC	NC	PC	PC	PC	PC	PC	PC	PC	PC	PC
Michigan	90.00	NC	NC	67.50	67.50	315.00	157.50	112.50	247.50	135.00	315.00	270.00
Wisconsin:												
Madison	75.00	C	C	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC
Milwaukee	75.00 or 100.00	NC	NC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC
West North Central:												
Minnesota	100.00	C	C	56.25	56.25	300.00	150.00	112.50	225.00	131.25	300.00	225.00
Iowa	60.00	C	C	45.00	30.00	210.00	90.00	75.00	150.00	90.00	180.00	150.00
Missouri:												
Kansas City	90.00	C	C	75.00	75.00	350.00	150.00	150.00–175.00	250.00	150.00	300.00	275.00
St. Louis	50.00	C[2]	NS	50.00	25.00	175.00	100.00	50.00	125.00	75.00	150.00	150.00
North Dakota	125.00	NC	NC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC
South Dakota	64.75	NC	NC	NA	NA	NA	NA	NA	NA	NA	NA	NA
Nebraska	90.00	NC	NC	75.00	50.00	350.00	150.00	75.00–125.00	250.00	150.00	300.00	250.00
Kansas	NS	NC	NC	PC	PC	PC	PC	PC	PC	PC	PC	PC
South Atlantic:												
Delaware	90.00	NC	NC	75.00	58.00	300.00	150.00	113.00	225.00	150.00	267.00	250.00
Maryland	100.00	C[2]	C[23]	75.00	60.00	275.00	150.00	115.00	200.00	150.00	225.00	225.00
District of Columbia	94.00	NC	NC	77.00	60.00	306.00	153.00	115.00	230.00	153.00	264.00	255.00

See codes and footnotes at end of table.

TABLE 3–4.—Blue Shield plans: Allowances for specific services—Continued

Region and State	Medical visits in hospital [1]					Maximum benefit (amount or days)*	Days required for new admission	Payments to nonparticipating physicians	
	1st day	2nd day	3rd day	4th day	Subsequently			In plan area	Outside plan area
New England:									
Maine	$4.00	$4.00	$4.00	$4.00	[3]	[4]	[4]	75%S	FS
New Hampshire-Vermont	5.00	3.00	3.00	3.00	$3.00/day	120d	NS	FS	FS
Massachusetts	10.00	5.00	5.00	5.00	$5.00/day	120d	90	50%S [5]	FS
Rhode Island	5.00	5.00	5.00	5.00	[6]	$406.00	90	[7]	[7]
Connecticut				6.00	[8]	[9] 500.00		FS	FS
Middle Atlantic:									
New York:									
Albany	15.00	10.00	5.00	5.00	$5.00/day	350.00		FS	FS
Buffalo	15.00	10.00	5.00	5.00	[10]	120d	90	FS	FS
Jamestown								80%S	FS
New York City	7.00	7.00	7.00	7.00	[11]	201d		FS	FS
Rochester	NA	NA	NA	NA	NA	120d	60	90%S	FS
Syracuse	12.30	8.20	4.50	4.50	4.50	[12] 120d		FS	FS
Utica	15.00	10.00	5.00	5.00	[13]	120d	90	FS	FS
New Jersey	15.00	10.00	6.00	6.00	[14]	211	90	FS	FS
Pennsylvania	[15]	[15]	[15]	[15]	[15]	70d	90	FS [5]	FS
East North Central:									
Ohio:									
Cleveland	[4] 15.00	5.00	5.00	5.00	[16]	120d	90	FS	FS
Columbus	10.00	5.00	5.00	5.00	$4.00/day	[17] 120d		[18]	[18]
Indiana	NA	NA	NA	NA	NA	120d	90	[18]	[18]
Illinois:									
Chicago	6.00	6.00	6.00	6.00	[19]	120d	90	FS	FS
Rockford	PC	PC	PC	PC	PC	365d	90	PC	PC
Michigan	15.00	6.00	6.00	6.00	[20]	120d	90	FS	FS
Wisconsin:									
Madison	UCRC	UCRC	UCRC	UCRC	UCRC			UCRC	UCRC
Milwaukee	UCRC	UCRC	UCRC	UCRC	UCRC			UCRC	UCRC
West North Central:									
Minnesota	15.00	5.00	5.00	5.00	$5.00	[21] 180d		FS	FS
Iowa	9.00	3.00	3.00	3.00	3.00	365d	90	FS	FS
Missouri:									
Kansas City	NA	NA	NA	NA	NA	70d	90	FS	FS
St. Louis		5.00	5.00	5.00	[22]	70d	90	50%S [5]	FS [5]
North Dakota	UCRC	UCRC	UCRC	UCRC	UCRC	365d	90	UCRC	UCRC
South Dakota	5.00	5.00	5.00	5.00	5.00	70d	90	FS	FS
Nebraska	10.00	5.00	5.00	5.00	5.00	150d	60	FS	FS
Kansas	PC	PC	PC	PC	PC	120d	90	PC	PC
South Atlantic:									
Delaware				5.00	5.00	5.00	90d	90	FS
Maryland	20.00	8.00	8.00	6.00	6.00	30d	90	FS	FS
District of Columbia				5.00	5.00	177d	NS	FS	FS

See Codes and footnotes at end of table.

TABLE 3-4.—Blue Shield plans: Allowances for specific services—Continued

Region and State	Obstetrical			Surgery								
	Normal delivery (4821)	Covers— Pre-natal care	Covers— Post-natal care	Fracture colles (0807)	Tonsillectomy and adenoidectomy, child (2992)	Gastrectomy (3115)	Appendectomy (3261)	Hemorrhoidectomy (3380)	Colecystectomy (3515)	Hernia (3631)	Prostatectomy (4321)	Panhysterectomy (4617)
South Atlantic—Con.												
Virginia:												
Richmond	UCRC	NC	NC [23]	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC	UCRC
Roanoke	$150.00	C	C	$90.00	$70.00	$360.00	$180.00	$135.00	$270.00	$180.00	$310.00	$300.00
West Virginia:												
Bluefield	93.50	NC	NS	76.50	59.50	306.00	153.00	114.75	229.50	153.00	263.50	255.00
Charleston	75.00	NC	NC	75.00	45.00	200.00	115.00	75.00	150.00	100.00	175.00	150.00
Clarksburg	75.00	NS	NS	60.00	45.00	235.00	120.00	85.00	180.00	115.00	205.00	195.00
Huntington	75.00	NC	NC	75.00	50.00	250.00	125.00	100.00	150.00	125.00	200.00	200.00
Morgantown	75.00	NC	NC	65.00	50.00	200.00	125.00	75.00	150.00	100.00	150.00	175.00
Parkersburg	95.00	NC	C	70.00	60.00	315.00	160.00	120.00	235.00	160.00	270.00	265.00
Wheeling	75.00	NC	NS	65.00	50.00	250.00	125.00	95.00	190.00	125.00	215.00	210.00
North Carolina	60.00	NS	NS	75.00	35.00	175.00	100.00	60.00	150.00	75.00	150.00	175.00
South Carolina	80.00	NC	NC	70.00	50.00	270.00	135.00	100.00	200.00	135.00	230.00	225.00
Georgia:												
Atlanta	75.00	NC	NC	125.00	42.50	200.00	125.00	80.00	175.00	100.00	175.00	175.00
Columbus	75.00	NC [29]	NC [29]	45.00	38.00	188.00	113.00	75.00	150.00	113.00	150.00	150.00
Florida	83.00	NC	NC	67.00	50.00	233.00	117.00	100.00	233.00	117.00	233.00	200.00
East South Central:												
Kentucky	50.00	NS	NS	35.00	30.00	175.00	100.00	85.00	150.00	75.00	150.00	150.00
Tennessee:												
Chattanooga	60.00	NS	NS	90.00	50.00	210.00	115.00	90.00	165.00	115.00	210.00	180.00
Memphis	60.00	NC	NC	45.00	50.00	210.00	115.00	90.00	165.00	115.00	210.00	180.00
Alabama	50.00	NS	NS	35.00	25.00	150.00	100.00	50.00	100.00	75.00	75.00	150.00
Mississippi	50.00	C	C	NA	NA	NA	NA	NA	NA	NA	NA	NA
West South Central:												
Arkansas	60.00	NS	NS	IC	35.00	210.00	120.00	90.00	165.00	90.00	210.00	180.00
Oklahoma	90.00	NS	NS	75.00	60.00	295.00	150.00	110.00	225.00	140.00	255.00	240.00
Texas	70.00	C	C	55.00	45.00	220.00	110.00	85.00	165.00	110.00	190.00	185.00
Mountain:												
Montana	157.50	C	C	81.00	67.50	360.00	157.50	135.00	270.00	157.50	270.00	270.00
Idaho	190.00	NS	NS	IC	83.00	385.00	176.00	138.00	281.00	165.00	330.00	303.00
Wyoming	100.00	NS	NS	75.00	60.00	250.00	125.00	125.00	200.00	150.00	250.00	225.00
Colorado	100.00	NC	C	85.00	50.00	275.00	125.00	IC	250.00	125.00	250.00	250.00
New Mexico	UC	NS	NS	UC	UC	UC	UC	UC	UC	UC	UC	UC
Arizona	100.00	NS	NS	78.00	53.00	254.00	124.00	106.00	196.00	129.00	274.00	215.00
Utah	50.00	NS	NS	112.50	67.50	360.00	135.00	121.50–157.50	225.00	157.50	225.00	225.00
Pacific:												
Washington:												
Bremerton	80.00	C	C	60.00	60.00	320.00	160.00	160.00	240.00	140.00	320.00	240.00
Seattle	75.00	C	C	100.00	75.00	450.00	215.00	150.00	300.00	185.00	375.00	325.00
Seattle (WPS)	100.00	C	C	NA	NA	NA	NA	NA	NA	NA	NA	NA
Spokane	154.00	C	C	99.00	66.00	352.00	176.00	137.50	275.00	154.00	302.50	264.00
Tacoma	NS	NC	NC	128.00	75.00	360.00	180.00	124.00	250.00	150.00	300.00	250.00
Walla Walla	75.00	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Wenatchee	75.00	NS	NS	68.00	68.00	360.00	180.00	135.00–180.00	270.00	158.00	360.00	270.00
Oregon	NS	C	C	NS	NS	NS	NS	NS	NS	NS	NS	NS
California	35.00	NC	NC	75.00	75.00	400.00	200.00	150.00	300.00	175.00	400.00	300.00
Hawaii	100.00	C	C	UC	UC	UC	UC	UC	UC	UC	UC	UC

See codes and footnotes at end of table.

TABLE 3-4.—Blue Shield plans: Allowances for specific services—Continued

Region and State	Medical visits in hospital [1]					Maximum benefit (amount or days)*	Days required for new admission	Payments to nonparticipating physicians	
	1st day	2nd day	3rd day	4th day	Subsequently			In plan area	Outside plan area
South Atlantic—Con.									
Virginia:									
Richmond	UCRC	UCRC	UCRC	UCRC	UCRC	120d	90	(24)	(24)
Roanoke	$18.00	$12.00	$6.00	$6.00	(25)	70d	90	FS	FS
West Virginia:									
Bluefield				5.00	$5.00	70d	90	FS	FS
Charleston				5.00	5.00	67d	90	FS	FS
Clarksburg	10.00	5.00	5.00	5.00	(26)	[12] 70d		FS	FS
Huntington			10.00	5.00	5.00	$145.00		75%S	75%S
Morgantown	10.00	5.00	4.00	4.00	4.00	[27] 30d		FS	FS
Parkersburg	13.00	8.00	6.50	6.50	(28)	70d	90	FS	FS
Wheeling	11.25	7.50	3.75	3.75	3.75	70d	90	50%S	75%S
North Carolina	10.00	7.50	5.00	5.00	5.00	70d	NS	FS	FS
South Carolina								FS	FS
Georgia:									
Atlanta								(18)	(18)
Columbus	5.00	5.00	5.00	5.00	5.00	[9] 28d		FS	FS
Florida	12.00	5.00	5.00	5.00	5.00	31d	90	FS	FS
East South Central:									
Kentucky				5.00	5.00	[12] $135.00		75%S	FS
Tennessee:									
Chattanooga				4.00	4.00	70d	90	(18)	(18)
Memphis					[30] 3.00	[9] 26d		FS	FS
Alabama				5.00	(31)	70d	NS	(18)	(18)
Mississippi				3.00	3.00	50d	90	(18)	(18)
West South Central:									
Arkansas	4.00	4.00	4.00	4.00	4.00	120d	90	75%S	FS
Oklahoma				7.00	(32)	30d	90	(18)	(18)
Texas	6.00	6.00	6.00	6.00	(33)	[12] $300.00		(18)	(18)
Mountain:									
Montana	17.00	5.00	5.00	5.00	5.00	120d	7	FS	FS
Idaho	NS	NS	NS	NS	NS	[9] 120d		FS	FS
Wyoming	6.00	[4] 6.00	6.00	6.00	[4] 6.00	120d	90	FS	FS
Colorado	5.00	5.00	5.00	5.00	(34)	120d	90	FS	FS
New Mexico	UC	UC	UC	UC	UC	365d	90	UC	UC
Arizona	13.50	[4] 4.50	4.50	4.50	[4] 4.50	120d	90	[5] FS	FS
Utah	[35] NS	NS	NS	NS	NS	70d	90	75%S	FS
Pacific:									
Washington:									
Bremerton	(36)	(36)	(36)	(36)	(36)	(37)	(37)	NS	NS
Seattle	NS	NS	NS	NS	NS	[9] 100d		NS	[5] FS
Seattle (WPS)	NA	NA	NA	NA	NA	[38] 120d		None	SS
Spokane	(36)	(36)	(36)	(36)	(36)	[39] 70d		NS	[5] FS
Tacoma	NS	NS	NS	NS	NS	[40] 90d		[5] FS	[5] FS
Walla Walla	(36)	(36)	(36)	(36)	(36)	[39] 70d		(41)	(41)
Wenatchee	NS	NS	NS	NS	NS	NS	NS	FS	FS
Oregon	NS	NS	NS	NS	NS	[12] 70d		SS	SS
California	NS	NS	NS	NS	NS	100d	30	FS	FS
Hawaii	80%UC	80%UC	80%UC	80%UC	80%UC	[9] 150d		80%UC	80%UC

See codes and footnotes on next page.

TABLE 3–4.—Blue Shield plans: Allowances for specific services—Continued

*Per admission unless otherwise noted.
D Days.
C Covered.
NC Not covered.
NS Not specified.
NA Not available.
S Scheduled allowances.
FS Full schedule.
SS Special schedule (for nonparticipating physicians).
IC Independent consideration.
UCRC Usual, customary, aud reasonable charges.
PC Prevailing charges.
UC Usual charges.

[1] Allowances are for regular cases. Many plans will pay more in cases where intensive care by the physician is required.
[2] Covered in the hospital only.
[3] $4 a day through the seventh day; $3 a day thereafter.
[4] Depends on specifications in the required concurrent Blue Cross contract.
[5] In emergency cases only.
[6] $5 a day for next 10 days and $4 a day for the next 84 days.
[7] In plan area—up to 80 percent of the mean of the prevailing range for each procedure for participating physicians; outside plan area—up to the prevailing level for each procedure for participating physicians.
[8] $6 a day for the first 4 payable days, $5 a day for the next 10 days, and $4 a day thereafter.
[9] In each calendar year.
[10] $5 a day the fifth to the fortieth day and $3 thereafter.
[11] $7 a day through the seventh day; $6 a day the eighth through fourteenth day; $5 a day the fifteenth through seventieth day; $4 a day thereafter.
[12] During contract year.
[13] $5 a day through the ninetieth day; $4 a day thereafter.
[14] $6 a day for the fifth through the fourteenth day; $5 a day thereafter.
[15] $20 or $30 the first day; $5, $7, or $10 for each subsequent day depending on the time, skill, and effort expended by the doctor.
[16] $5 a day through the thirtieth day and $4 a day thereafter.
[17] During 12-month period.
[18] No participating agreements with physicians. Pays full schedule to all physicians.
[19] $6 for the fifth day; $4 a day thereafter.
[20] $6 a day through the twentieth day; $4.80 a day thereafter.
[21] For illnesses due to the same cause, 180 days per contract year.
[22] $5 a day through the seventh day; $3 a day thereafter.
[23] Covered in hospital only except if delivery occurs outside the hospital; postnatal care is covered for two weeks after delivery.
[24] In plan area—regular charges or scheduled allowances, whichever is lesser. Outside plan area—regular charges or the average amount currently being paid to participating physicians, whichever is the lesser.
[25] $6 a day through the fourteenth day; $4 a day thereafter.
[26] $5 a day through the fourteenth day; $4 a day thereafter.
[27] In each calendar year for any one period of disability or for successive periods of disability due to the same related cause or causes.
[28] $6.50 a day the fifth and sixth days; $5 a day thereafter.
[29] Except in home deliveries.
[30] $3 a day beginning with fifth day.
[31] $5 a day through the thirteenth day; $3 a day thereafter.
[32] $7 a day through the fifteenth day; $5 a day thereafter.
[33] $6 a day for the fifth day, $5 a day for the next five days, $4 a day thereafter.
[34] $5 a day up to the fifteenth day and $4 a day thereafter.
[35] Services paid by relative value beginning the first day of hospitalization.
[36] All necessary in-hospital medical care paid in full.
[37] Benefits renewable each certificate year.
[38] During membership year for any one illness, injury, or condition.
[39] Per condition.
[40] During any one year for any one illness or condition.
[41] Plan reimburses subscriber reasonable expenses for services of all nonparticipating physicians but shall not exceed an aggregate of $500 as to any one sickness or injury.

TABLE 3–5.—Blue Shield plans: Waiting period for maternity benefits and special conditions covered or not covered

[Restrictions on specific services or conditions—exclusions or waiting periods]

Region, State, and plan	Maternity (waiting period in months)	Mental illness	Tuberculosis	Alcoholism	Drug addiction	Cosmetic surgery	Pre-existing conditions	Venereal disease	Sterilization	Tonsillectomy and adenoidectomy	Other conditions (waiting periods or exclusions)
New England:											
Maine	9	C	C	C	C	C [1]	12 mo.	C	C	C	
New Hampshire-Vermont	9	C	C	C	C	C [1]	9 mo.	C	C	9 mo.	(2)
Massachusetts	9	10-B-life	10-B-life	C	C	C	C	C	C	C	
Rhode Island	7	C	C	C	C	C [1]	7 mo.	C	C	C	
Connecticut	8	C	C	C	C	NC	C	C	C	C	
Middle Atlantic:											
New York:											
Albany	9	30-B-con [3]	30-B-con [3]	C	C	NC	11 mo.	NC	C	6 mo.	
Buffalo	9	C [4]	NC [5]	C	C	NC	11 mo.	C	C	6 mo.	(6)
Jamestown	10	C [4]	C	C	C	NC	NC	C	NC	6 mo.	
New York City	10	30-B-con	30-B-con	C	C	NC	11 mo.	C	C	6 mo.	(7)
Rochester	10	NC	NC	NC	NC	NC	12 mo.	C	12 mo.	6 mo.	(8)
Syracuse	10	C	C	C	C	NC	11 mo.	C	C	6 mo.	(7)
Utica	10	C [4]	NC [5]	C	C	NC	11 mo.	C	C	6 mo.	
New Jersey	8	C	C	C	C	C	C	C	C	C	
Pennsylvania	9	30-B-yr.	30-B-yr.	C	C	NC [9]	C	30-yr.	C	C	
East North Central:											
Ohio:											
Cleveland	9	C	C	C	C	C	C	C	C	C	
Columbus	9	C	C	C	C	NC	C	C	C	C	
Indiana	9	30-A-180	30-A-180	C	C	NC	9 mo.	C	C	6 mo.	
Illinois:											
Chicago	9	C	C	C	C	(10)	C	C	C	C	
Rockford	9	30-A-180	30-A-180	C	C	NC [11]	C	C	NC	C	
Michigan	9	30-A-180	30-A-180	C	C	NC [11]	C	C	NC	C	
Wisconsin:											
Madison	9	C	C	C	C	NC [9]	C	C	C	C	
Milwaukee	9	C	C	C	C	NC	9 mo.	C	C	9 mo.	
West North Central:											
Minnesota	9	C	C	C	C	C [1]	C	C	NC	C	
Iowa	9	C	30-A-180	30-A-180	30-A-180	C [1]	11 mo.	C	C	9 mo.	(12)
Missouri:											
Kansas City	9	30-B-yr.	C	14-B-yr.	14-B-yr.	NC [9]	12 mo.	C	C	6 mo.	
St. Louis	9	C	C	C	C	NC	NC	C	C	10 mo.	
North Dakota	9	70-A-180 [13]	70-A-180	C	C	C	9 mo.	C	C	9 mo.	
South Dakota	9	70-A-180	70-A-180	70-A-180	70-A-180	NC	11 mo.	C	C	9 mo.	
Nebraska	9	30-A-180	30-A-180	30-A-180	30-A-180	NC	9 mo.	C	NC	9 mo.	(14)
Kansas	8	30-B-con	C	30-B-con	30-B-con	NC [15]	8 mo.	C	C	C	(16)
South Atlantic:											
Delaware	9	60-A-90	NC	C	C	NC	12 mo.	C	C	12 mo.	(17)
Maryland	8	30-A-180	NC	C	C	NC [9]	9 mo.	C	C	6 mo.	(7)
District of Columbia	10	C	C	C	C	C [1]	10 mo.	C	C	10 mo.	

See codes and footnotes at end of table.

TABLE 3-5.—Blue Shield plans: Waiting period for maternity benefits and special conditions covered or not covered—Continued

[Restrictions on specific services or conditions—exclusions or waiting periods]

Region, State, and plan	Maternity (waiting period in months)	Mental illness	Tuberculosis	Alcoholism	Drug addiction	Cosmetic surgery	Pre-existing conditions	Venereal disease	Sterilization	Tonsillectomy and adeoidnectomy	Other conditions (waiting periods or exclusions)
South Atlantic—Con.											
Virginia:											
Richmond	9	12 mo.	12 mo.	12 mo.	12 mo.	NC	12 mo.	C	12 mo.	12 mo.	[18]
Roanoke	9	30-B-yr.	30-B-yr.	NC	NC	NC	12 mo.	C	C	6 mo.	----------
West Virginia:											
Bluefield	9	30-B-cal	30-B-cal	NC	NC	NC [9]	9 mo.	C	C	9 mo.	----------
Charleston	9	30-B-cal	30-B-cal	NC	NC	NC [9]	9 mo.	C	C	9 mo.	[19]
Clarksburg	9	NC	NC	NC	NC	NC	C [20]	C	C	6 mo.	[21]
Huntington	9	NC	NC	NC	NC	NC	6 mo.	C	C	6 mo.	[22]
Morgantown	9	NC	NC	NC	NC	C	6 mo.	NC	C	6 mo.	[23]
Parkersburg	9	30-B-cal	NC	NC	NC	NC [9]	6 mo.	C	C	6 mo.	----------
Wheeling	9	30-B-ca.	30-B-cal	C	C	C	9 mo.	C	C	9 mo.	----------
North Carolina	9	30-B-yr.	30-B-yr.	C	C	C	12 mo.	C	C	C	----------
South Carolina	10	C	C	NC	NC	NC	12 mo.	C	C	C	----------
Georgia:											
Atlanta	10	C [24]	C [24]	C	C	NC	12 mo. [25]	C	C	6 mo. [27]	[26]
Columbus	9	C	C	NC	NC(m)	C	12 mo.	C	C	C	----------
Florida	9	31-B-con	31-B-con	31-B-con	31-B-con	NC	C	C	C	C	----------
East South Central:											
Kentucky	9	C	NC	C	C	NC	C	C	C	C	----------
Tennessee:											
Chattanooga	9	C	C	C	C	NC	12 mo.	C	C	12 mo.	----------
Memphis	9	30-B-life	30-B-life	NC	NC	C	C	NC	C	C	----------
Alabama	9	C [27]	C [27]	C [27]	C [27]	NC	9 mo.	C [27]	C [27]	9 mo.	----------
Mississippi	9	C	C	C	C	NC	NC	C	C	C	----------
West South Central:											
Arkansas	9	28-B-yr.	28-B-yr.	NC	NC	NC [9]	12 mo.	C	C	12 mo.	[16]
Oklahoma	9	27-B-yr.	NC	NC	NC	NC [9]	C	C	NC	9 mo.	[28]
Texas	9	C	C	C	C	C	12 mo.	C	C	C	----------
Mountain:											
Montana	9	30-B-con	NC	30-B-con	C	NC	6 mo.	C	NC	6 mo.	[29]
Idaho	10	30-B-cal	45-B-cal	30-B-cal	30-B-cal	NC	12 mo.	C	C	10 mo.	[30]
Wyoming	9	30-B-con	30-B-con	NC	NC	NC	11 mo.	C	C	11 mo.	[16]
Colorado	9	30-B-con	30-B-con	21-B-life	C	NC	11 mo.	C	C	11 mo.	[31]
New Mexico	9	30-B-con [32]	30-B-con [32]	30-B-con [32]	30-B-con [32]	NC [33]	C	C	C	6 mo.	[31]
Arizona	9	30-B-yr.	30-B-yr.	30-B-yr.	30-B-yr.	NC	11 mo.	C	NC	6 mo.	----------
Utah	9	21-A-90	21-A-90	C	C	NC [33]	6 mo.	C	C	6 mo.	----------
Pacific:											
Washington:											
Bremerton	10	C	C	C	C	C	C	C	C	C	----------
Seattle	9	NC	NC	NC	NC	NC [9]	6 mo.	C	NC	6 mo.	[35]
Seattle (W.P.S.)	NA	C	C	NC	NC	NC	C	C	NC	C	----------
Spokane	11	NC	C	NC	NC	C [36]	12 mo.	NC	C	12 mo.	[37]
Tacoma	10	NC	NC	NC	NC	NC	10 mo.	NC	NC	6 mo.	[38]
Walla Walla	10	C	C	NC	NC	NC	6 mo.	C	NC	6 mo.	[39]
Wenatchee	9	35-B-cal	C	C	C	NC	6 mo.	C	NC	6 mo.	[40]
Oregon	10	NC	NC	NC	NC	NC	C	C	NC	6 mo.	[41]
California	9	NC	C	C	C	C	C	C	C	C	----------
Hawaii	9	30-B-cal	NC	C	C	NC	C	C	NC	C	----------

See codes and footnotes on next page.

TABLE 3–5.—Blue Shield plans: Waiting period for maternity benefits and special conditions covered or not covered—Continued

C Covered.
NC Not covered.
NA Not available.
B During specified period.
A Per admission (with specified period required between admissions).
Con Contract year.
Cal Calendar year.
Yr Year (any 12-month period).

1 Covered if need is not pre-existing.
2 A waiting period of 9 months for services for hernia, varicose veins, hemorrhoids, any condition involving the female genital system, and congenital abnormalities except for eligible newborn.
3 In the aggregate for mental illness and tuberculosis.
4 Covered if not functional.
5 Except for surgical care rendered in such cases.
6 Excludes services for treatment of warts and certain defined conditions of the feet.
7 Excludes care for listed conditions of the feet.
8 A waiting period of 12 months for treatment for hernia, thyroid or goiter conditions, hemorrhoids and other rectal conditions, duodenal or gastric ulcers, gall bladder disease, and varicose veins.
9 Unless for conditions resulting from accidents and/or disabling or traumatic conditions occurring while covered by plan.
10 Excludes plastic operations unless necessary to correct traumatic injuries or congenital deformities evidenced in infancy.
11 Exclusion does not apply to the correction of congenital anomalies if the member is less than 12 years old and has been covered since birth or in cases of accidental injuries or surgical scars provided such conditions shall have had their origin while covered.
12 Excludes dental care except when surgical removal of impacted teeth is required for a bed patient or when necessitated by accidental injuries incurred while covered by plan.
13 Maximum allowance of $500 in a calendar year, including shock therapy.
14 A waiting period of 9 months for treatment for appendectomy (except acute cases), hernia, hemorrhoids, varicose veins, duodenal or gastric ulcers, gall bladder disease, thyroid or goiter conditions, hysterectomy, tumors of the uterus, and other specified conditions. Excludes care for intentionally self-inflicted injuries.
15 Not covered for persons age 21 and over except for accidental injuries incurred after effective date of contract.
16 Excludes care for intentionally self-inflicted injuries.
17 A waiting period of 9 months for hernia and hemorrhoids.
18 A waiting period of 12 months for hernia and all elective surgery.
19 A waiting period of 9 months for hernia, hemorrhoids or gall baldder, and for appendectomy when performed at the same time of other abdominal surgery.
20 No limitations on groups of 5 or more. Not covered for other groups.
21 All benefits for illness subject to waiting period of at least 30 days. A waiting period of 1 year for hernia and thyroid conditions. Excludes care for intentionally self-inflicted injuries.
22 Excludes care for bruises, strains, and contusions.
23 A waiting period of 6 months for diseases or ailments peculiar to women. Excludes intentionally self-inflicted injuries.
24 Plan does not specifically exclude these conditions although in-hospital medical care is not covered.
25 No waiting period for groups of 25 or more.
26 A waiting period of 6 months for hernia and hemorrhoids.
27 Covered if covered by hospital certificate to which the most widely held surgical certificate is a rider.
28 A waiting period of 9 months for care of hemorrhoids, hernia, and care related to ovaries, tubes, uterus, prostate, varicose veins, and gall bladder.
29 A waiting period of 6 months for care of congenital conditions, cholecystitis, hernia, hemorrhoids, prostatic hypertrophy, diseases and injuries of the female generative tract, appendicitis, appendectomies, and prostatectomies.
30 A waiting period of 12 months for coverage of chronic conditions and diseases peculiar to, or of organs peculiar to, either the male or female sex.
31 A waiting period of 11 months for care of gall bladder diseases, and ulcers of the stomach or duodenum.
32 A waiting period of 9 months applies.
33 Not covered unless to correct functional disorders or to repair damage resulting from accidental injury while covered by plan.
34 A waiting period of 9 months for care for arthritis, asthma, cancer, congenital anomalies, diserders of the gall bladder, genitalia disorders, hemorrhoids, hernia, prestate disorders, tumor, ulcers, disorders of the urinary or cardiovascular system, and varicose veins.
35 A waiting period of 6 months for surgery or conditions of the female pelvis, surgery fer repair of hernia; and surgery, radium, or deep X-ray therapy for cancer.
36 When for relief of scarring disability which hampers normal physical activity, following injury due to an accident.
37 A waiting period of 12 months for care of varicose veins, female surgery, and hernias; care for self-inflicted injuries is not covered.
38 Excludes services for self-inflicted injuries and epilepsy.
39 A waiting period of 6 months for care of allergies, asthma, arthritis, cardiovascular or renal conditions, female pelvic conditions, diabetes, prostatitis, disease or defects of the spine, gall bladder disease, gastrointestinal ulcers, hemorrhoids, thyroid, hernia, varicose veins, tumors, and malignancies. Excludes services for self-inflicted injuries and conditions active or under treatment on effective date of contract.
40 A waiting period of 6 months for hernia, cardiac, vascular, and cancerous or tumorous conditions.
41 A waiting period of 6 months for care of allergies, arthritis, cardiovascular disease, diabetes, diseases or defects of spinal column, diseases or defects of the male or female reproductive organs, gall bladder disease, gastrointestinal ulcers, heart disease, hernia, hemorrhoids, hypertension, kidney stones, known congenital defects, menopause, rectocele, thyroid conditions, and varicose veins.

TABLE 3-6.—Blue Shield plans: Age limits for children and coordination of benefit provisions

Region, State, and plan	Age limits: Newborn (days after birth)	Age limits: Unmarried children (years)	Unmarried children over limit incapable of self-support	Coordination of benefit provisions
New England:				
Maine	[1]	19		
New Hampshire-Vermont		19		
Massachusetts		19	X [2]	
Rhode Island	[3]	19	X	
Connecticut		19		
Middle Atlantic:				
New York:				
Albany		19		
Buffalo		19		
Jamestown	96	19		
New York City		19	X	
Rochester	[4]	19		
Syracuse		19		
Utica	14	19		
New Jersey		19	X	
Pennsylvania		19		
East North Central:				
Ohio:				
Cleveland		19		
Columbus	[5]	19		
Indiana		19		
Illinois:				
Chicago		19		
Rockford		19		
Michigan		19		
Wisconsin:				
Madison		19		
Milwaukee		19		
West North Central:				
Minnesota		19		
Iowa		[6] 19	X	
Missouri:				
Kansas City		19		X
St. Louis	90	19		
North Dakota		[6] 19	X	
South Dakota		[7] 19		
Nebraska		19		X
Kansas	[5]	21		X
South Atlantic:				
Delaware		19	X	X
Maryland	[9] 10	19	X	
District of Columbia	14	19	X	X
Virginia:				
Richmond		19		
Roanoke		19		
South Atlantic—Con.				
West Virginia:				
Bluefield	15	19		
Charleston	30	19		
Clarksburg	42	19		
Huntington		19		
Morgantown	90	19		
Parkersburg		19		
Wheeling		19		
North Carolina		19		
South Carolina		[10] 19	X [10]	
Georgia:				
Atlanta		19		
Columbus	[11] 15	19		
Florida		19		
East South Central:				
Kentucky	30	19		
Tennessee:				
Chattanooga	15	19		
Memphis		19		
Alabama		19		
Mississippi	14	19		
West South Central:				
Arkansas		19		
Oklahoma		19		
Texas	[12]	19		
Mountain:				
Montana		19		
Idaho	[13] 15	[14] 19	[14]	X
Wyoming	[15]	19		
Colorado		19		
New Mexico		[16] 19	X	
Arizona		19		
Utah		19		
Pacific:				
Washington:				
Bremerton		NA		
Seattle	30	19		X
Seattle (W.P.S.)	30	19		
Spokane	30	19		
Tacoma		NA		
Walla Walla	30	18		
Wenatchee		19		X
Oregon	14	19		
California		[17] 19		X
Hawaii		19		X

NA Data not available.

[1] Surgery from birth; medical care available after mother's discharge from hospital.

[2] If additional subscription charge is paid.

[3] The infant shall become a subscriber entitled to all benefits of membership when a surgical procedure is performed on the child, when the mother or child is discharged from the hospital, or when the child has attained the age of 14 days, whichever occurs first.

[4] Covered from birth except for in-hospital medical benefits in which case the newborn child shall be entitled to coverage from the time the mother leaves the hospital.

[5] Covered from birth except that benefits for in-hospital medical care begin after 30 days.

[6] Plan also covers unmarried dependent children who are full-time students regardless of age.

[7] Covers unmarried full-time students to age 23.

[8] Covered from birth except that until the mother is discharged from the hospital, nonsurgical services will not be provided unless the newborn is premature or ill.

[9] Benefits from birth for correction of congenital defects, serious birth injuries or infections, or if child weighs less than about 5 pounds (2,500 grams).

[10] Dependent child covered to age 23 if a student in an accredited academic institution or if physically or mentally incapacitated.

[11] Covered from birth for correction of congenital anomalies.

[12] Covered from birth except for medical benefits which are available when newborn is 45 days old.

[13] Covered from birth for congenital conditions, prematurity, and exchange transfusions.

[14] Plan covers dependent children over 19 as long as they are shown as dependent on the subscriber's most recent U.S. individual income tax return, but not beyond the 25th birthday.

[15] Covered from birth except for medical care which becomes available after 7 days or the day after the mother leaves the hospital, whichever occurs first.

[16] Or to age 25 if a full-time student.

[17] Or to age 23 if a full-time student.

Chapter 4

INSURANCE COMPANIES—GROUP POLICIES

Over 700 companies in the United States write group accident and health insurance policies; virtually all of these companies write both hospital-medical and disability coverages.[1] The number of different policies and options written by individual companies, if one takes into account both the main types of coverages (hospital, surgical, major medical, etc.) and all the minor variations in benefit levels and provisions, run into the hundreds or thousands. Because of the large number of companies and the innumerable variations in policies available it is not possible to identify any particular policies as being the most widely sold, as in the case of the Blue Cross and Blue Shield plans.

As a consequence, the only feasible procedure seemed to be to give a general description of the main types of coverages offered by the leading insurers. The following description is based upon material—specimen copies of policies, descriptive material, and group manuals (developed by the companies for their field representatives)—submitted by the 10 largest writers of group accident and health policies. These companies in 1967 wrote about 57 percent of the total premium volume of all group accident and health insurance.

This description of coverages is given a quantitative orientation by data on the number of persons covered for various types of benefits and benefit durations and levels, based on the results of a 1966 survey of group health insurance conducted by the Health Insurance Association of America.

The chapter concludes with a description of the high option of the Government-Wide Indemnity Plan offered to Federal employees under the Federal Employees Health Benefits program. This plan, offered by a consortium of insurance companies, is illustrative of the more comprehensive health benefit coverages currently written by insurance companies.

Under group policies covering health care expenses, insurance companies offer two general "plans" of benefits—basic benefit and major medical. The basic benefit plans provide "first dollar" coverage of expenses incurred for hospital care, surgical service, physician visits, and other items of care, generally without deductible or coinsurance features. The major medical plans are designed to cover medical expenses of major or catastrophic proportions, while avoiding coverage of small or minor expenses that, it is believed, most families can pay out-of-pocket without hardship.

Major medical plans are characterized by deductible and coinsurance features, cover most types of health care, and provide benefits up to relatively high maximums. They are of two types: (a) supplementary, which supplement plans of basic benefits, and (b) comprehensive, which have no basic coverages and furnish a complete and integrated coverage in one package. The first type covers more people than the second by a ratio of about 3 to 1.

Insurance company group coverage of health care expense began with the provision of basic benefits for hospital care and surgery. In 1949 policies of the major medical type began to be written and this type of insurance has since grown rapidly. Today, about 60–65 percent of the persons with hospital coverage under insurance company group policies are covered under supplementary or comprehensive major medical insurance.

[1] Two-thirds to three-fourths of the persons with health coverage provided by insurance companies, depending upon the index used, have such protection through group policies. Of the total premiums paid to insurance companies for health insurance almost three-fourths is for group coverage.

Basic Benefit Plans

Basic benefit plans commonly provide coverage of the expenses arising from hospital care, surgical (including obstetrical) service, physician in-hospital visits or alternatively visits in the hospital, office, and home, and out-of-hospital X-ray and laboratory examinations. Some companies offer basic coverage of other types of expense, e.g., care in skilled nursing homes or convalescent hospitals, radiotherapy, emergency accident care, home health services, dental care, prescription drugs, and vision care. Major medical policies generally cover all types of health care expense, excluding only dental care (other than that required because of an accident), routine health check-ups, eye refraction examinations, and eyeglasses.

Regardless of policy type, insurance company coverage provides for payment to the covered person of a benefit to defray or help defray the expenses incurred by him or a dependent for medical care. There are only two parties to the insurance contract, the insurance company and the insured employer or group; this is unlike the situation of Blue Cross or Blue Shield plans, which have contracts with hospitals or physicians as well as with insured persons. This circumstance gives insurance companies practically complete freedom as to the type of benefits they are able to write and, in general, companies will provide any type or scope of benefits that an employer, welfare fund, or union wants and is willing to pay for.

Insurance company group policies generally define dependents as the husband or wife of the employee and children between the ages of 14 days and 19 years. For an additional premium, coverage can be provided for infants from birth and for unmarried, dependent children up to the age of, say, 25 while they are attending school.

HOSPITAL EXPENSE BENEFITS

Hospital expense benefits typically provide allowances toward (a) the hospital's daily charges for room and board and (b) other hospital charges. The daily room and board benefit is generally set in relation to hospital room and board charges in the particular locality, i.e., practically never higher than prevailing charges for semi-private accommodations and usually somewhat lower. Typical plans provide benefits for 31, 70, 90, 120, or, less frequently, 365 days. Benefits for "other hospital charges" (use of operating room, laboratory and X-ray examinations, drugs, anesthesia service and supplies, ambulance, etc.) typically run in terms of a specified number of times the daily benefit, for example 10 or 20 times. Some plans cover these charges up to, say, 20 times the daily benefit and then pay 75 percent of additional charges, or cover them in full.

Benefits are provided for care in all types of hospitals. A typical policy defines a hospital as "an institution constituted and operated in accordance with the laws pertaining to hospitals, which provides for compensation, medical and surgical treatment for injury and sickness under the care of physicians on an inpatient basis, with continuous 24-hour nursing service by registered graduate nurses. It does not include an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home." It will be noted that this definition of hospitals does not exclude mental or tuberculosis hospitals; almost universally group policies cover care in such hospitals.

Except as regards obstetrics, insurance generally covers care for all conditions, i.e., there is generally no exclusion or diminution of benefits for mental illness or tuberculosis, etc.

Maternity benefits.—Hospital expense benefits may be written with or without maternity benefits. If included, the usual benefit is an allowance equal to a certain multiple, say, 10 times, of the daily benefit, or a flat stipulated amount; alternatively, full coverage may be provided, i.e., the same coverage as for other hospital confinements.

Generally, maternity benefits are payable only for a pregnancy that commenced after the effective date of the policy, i.e., in the case of a normal pregnancy, after 9 months. And, almost universally, in the event of cancellation of a policy or termination of an employee's employment, benefits will be provided for those maternities that commenced during the period of coverage, i.e., within a 9-month period. This is a different way of handling maternity benefits than that used under Blue Cross, which typically does not pay for confinements occurring after coverage terminates.

However, alternative arrangements that, in company manuals, bear such intriguing titles as "immediate maternity," "swap maternity," and "switch maternity" are available. Under "immediate maternity," available for the payment of an initial extra premium, pregnancies existing on the effective date of the plan will be covered. Under "swap maternity," if the previous policy covering the employee group did not provide for extension of maternity benefits after termination of coverage, "immediate maternity" benefits may be offered without an extra premium in exchange for elimination of the normal extension of maternity benefit provisions.

The "switch maternity" arrangement arises because it is the normal practice of Blue Cross and some insurance companies to provide dependent pregnancy benefits to a female employee whose husband is insured as a dependent and to exclude the usual employee's pregnancy benefits. Under "switch maternity," maternity benefits would be made available to the female employee, and husbands are included as eligible dependents. Since under this arrangement a working wife could obtain two maternity benefits, i.e., one under this policy and one under her husband's coverage as a dependent, insurance companies normally require in such cases that the entire medical care plan include coordination of benefit provisions. This last will be explained later.

Extension of benefits.—Typically, basic hospital benefits provide coverage for any hospital confinement commencing within 3 months after the termination of the insurance, provided the hospital confinement is solely for the treatment of an injury or a sickness that has caused the individual to be totally and continuously disabled from the day his insurance terminated until the commencement of the hospital confinement and the individual has not become insured under another group insurance plan providing medical care benefits.

General limitations.—Hospital expense plans typically will pay for any hospital confinement subject only to the following limitations: Benefits will not be paid for conditions covered under workmen's compensation; for expenses covered under a public program such as Medicare; for care in a hospital owned and operated by the Federal Government; and for expenses that the individual is not legally required to pay, or that are in excess of customary or necessary care or treatment.

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Charges covered.—Daily room and board benefits reimburse for charges for room and board. "Other charges" include all other items other than telephone, guest trays, etc.; fees or board of private duty nurses; and charges of physicians. However, policies generally provide that charges of physicians for X-ray and laboratory examinations and anesthesia service during a period of hospital confinement may be covered up to the overall maximum payment for "other hospital charges."

Hospital outpatient services.—Inpatient hospitale expense benefits will be provided, typically, only for a hospital confinement of not less than 18 hours. However, most policies provide that hospital charges will be paid in the case of a surgical operation performed on an outpatient basis, or that the hospital's charges for emergency room care, etc., will be paid for outpatient care of an accident within 24 hours of the accident.

NURSING HOME OR CONVALESCENT HOSPITAL EXPENSE BENEFITS

Within recent years, some companies have begun to write nursing home or convalescent hospital expense benefits.[2] Typically, such benefits cover charges for bed, board, and necessary services and supplies up to an amount equal to a specified rate per day multiplied by the number of days of confinement. Typically, the rate per day is 50 percent of the hospital daily benefit rate, with the maximum duration not exceeding that for hospital daily benefit. Benefits are available only when such confinement is recommended by a physician, begins within, say, 7 or 14 days of a hospital confinement of at least 3 or 5 consecutive days, and is for the same cause as, or a cause related to, that for the preceding hospital confinement. Some companies provide that benefits for nursing home or convalescent hospital expense are payable, after the above conditions are met, on the basis of, say, twice the unused, i.e., remaining, days of hospital daily benefits.

A nursing home or convalescent hospital typically is defined as an institution that provides room and board and 24-hour skilled nursing services

[2] Some companies use one term, others the other. Both denote the same type of institution.

under the full-time supervision of a physician or a registered graduate nurse and is not, other than incidentally, a place of rest, a place for the aged, for alcoholics, for drug addicts, for the blind or deaf, or for mentally ill or retarded persons. At least one company specifies that the institution must have qualified as an "extended-care facility" under the Federal Medicare program.

A number of companies are begining to write benefits covering the cost of home care under an organized home care program as an alternative to hospital or nursing home care.

SURGICAL EXPENSE BENEFITS

Surgical expense coverage provides payments toward expenses incurred for surgical care, generally in accordance with a schedule of allowances for the various procedures and operations. A number of schedules are used in policies currently being written. These include the 1947 and 1957 schedules of the Society of Actuaries, the California (Medical Association) Relative Value Studies, relative value schedules of other medical associations, and a number of other schedules. In general, schedules are defined in terms of the maximum amount that will be paid for any operation or any combination of operations in a particular disability. All of these schedules may be written in terms of specified multiples or unit values. For example, the 1947 Schedule of the Society of Actuaries, which has a maximum allowance of $200, might be written at 100, 120, 150, 175, or 200 percent.

The value of a particular schedule, of course, depends on more than just simply the particular maximum benefit provided since different procedures are valued differently in different schedules. A schedule that pays significantly more for the relatively frequent operations may yield much more in benefits overall than another schedule that pays less for these operations even though both pay the same for the relatively infrequent operations carrying the maximum allowance.

Within recent years some companies have written surgical expense coverages on an unscheduled basis, i.e., providing full reimbursement of regular, customary, and reasonable surgical charges.[3]

[3] Some of these have an overall maximum benefit that will be paid for any surgical episode.

A surgical expense coverage may or may not include obstetrical benefits. If it does, such benefits are normally payable only for pregnancies that commenced after the effective date of the policy; after coverage terminates, benefits are normally payable for pregnancies that commenced while coverage was in force. Analogous alternative arrangements are available as in the case of hospital expense maternity benefits.

Some schedules provide specific benefits for anesthesia. Thus the California Relative Value schedule carries specific allowances for anesthesia, the units being based upon a time factor, one unit for each 15 minutes or major part thereof. In most plans, however, anesthesia service as well as supplies are covered under the hospital plan.

BLANKET MATERNITY BENEFITS

In lieu of maternity benefits in connection with hospital expense and surgical expense policies, a plan of insurance may provide for blanket maternity benefits. Typically, these are benefits up to a specified amount—$200, $300, $400, etc.—to cover charges incurred for hospital expense and physician services during a pregnancy or for obstetrical delivery.

DOCTOR'S ATTENDANCE EXPENSE BENEFITS

A plan of doctor's attendance expense benefits may be limited to physician visits, other than surgical, during a period of hospital confinement or pay for visits in the office and home as well. Generally a plan limited to in-hospital visits provides a specified amount per day of hospital confinement, ranging from $3 to $8, for the same number of days of care as are provided for under the hospital expense plan. No payment is made for visits made on or after the day a surgical procedure is performed if benefits are provided under surgical expense benefits and the visit is made by the physician who performed or assisted in the surgical procedure. Also excluded are doctors' services in connection with pregnancy.

A plan including in-hospital doctor visit benefits may be broadened to include benefits for out-of-hospital physician visits. Benefits are in the form of specified amounts for each doctor visit in the office or home. The maximum payment per visit may be $3, $4, $5, or more per visit, subject to a

maximum payment for all home and office visits during a calendar year of, say, 50 times the maximum per visit.

Most plans provide for payment beginning with the first visit in the case of an accident and, say, the third or fourth visit in the case of sickness. Typically, payment is made for only one visit during any one day, and benefits are excluded for visits in connection with a pregnancy or for examinations for the prescription of eyeglasses or hearing aids.

In lieu of separate policies covering in-hospital and out-of-hospital visits, a single plan of insurance may be written covering doctors' visits in the hospital, office, and home. The benefit may be a specified uniform amount for all types of visits or may provide for a larger payment for a hospital or home visit than for an office visit. Payment is made for only one visit per day. Payment may begin with the first visit or, more usually, with the first visit in the hospital, the third or fourth visit in the office or home for a sickness, and the first visit for an injury. The maximum payment for all visits may be a specified amount such as $150, $250, $300, or more.

OUT-OF-HOSPITAL LABORATORY AND X-RAY EXAMINATION BENEFITS

Typical plans provide benefits only for X-ray examinations or for both X-ray and laboratory examinations and are on either a scheduled or unscheduled basis. Benefits are payments toward the charges incurred for these examinations up to a maximum for all such examinations during a calendar year. Typical maximums are $50, $75, or $100. Scheduled plans provide for payments on the basis of scheduled amounts for the various X-ray or laboratory examinations as set forth in a schedule of allowances. Benefits for both injury and sickness are provided.

EMERGENCY ACCIDENT EXPENSE BENEFITS

Some companies provide plans offering emergency accident expense benefits. These pay benefits toward the cost of treatment by a physician, medical supplies furnished by a physician, and ambulance service used to transport the patient from the scene of an accident to the nearest medical facility, when such costs are incurred as a result of an accidental bodily injury and within 48 hours of the accident. Benefits are limited to, say, $100 to $300 for injuries in any one accident. This benefit, one company states, "should appeal to many prospects as a method of providing a limited form of first dollar coverage for accidents and is recommended as an appropriate inclusion in basic medical care plans." This insurance would provide payment for that portion of expenses incurred as a result of an accidental bodily injury that exceeds the benefits to which the individual is otherwise entitled under the basic medical care plan.

DENTAL CARE BENEFITS

Over 3 million people are now covered for dental care expense under group policies of insurance companies. This type of insurance is growing rapidly. Much experimentation is going on and the situation is highly fluid.

Probably the most common type of plan is one that pays dental charges up to scheduled amounts for each procedure. Limits are frequently placed on the number of periodontia treatments per year; orthodontia is commonly excluded, or it may be included with the patient paying 40 or 50 percent of the charges up to specified limits. Generally a limit, say, $500, is placed on the total amount of benefits payable for a person in a year; for a slightly higher premium the limit will be removed.

Some plans pay 75 percent of dentists' usual and customary charges or specified allowances for each procedure, whichever is less. Some plans pay 75 percent of dentists' usual, customary, and reasonable charges, but these are uncommon. Some plans have a deductible, $25 or $50 each year. Variants are common, for example that a plan will cover periodontia treatments but only after the person has been covered for a year.

PRESCRIPTION DRUG EXPENSE BENEFITS

Although drugs are universally covered under major medical policies, coverage of drugs as a basic benefit is relatively new and experimental. Such insurance provides benefits for out-of-hospital prescribed drugs, i.e., drugs available only on a prescription basis and prescribed by a physician. An illustrative plan pays expenses incurred for drugs

up to a maximum of $250 in any one calendar year with a $25 deductible for each covered person or $75 for family. Some plans have a coinsurance feature, e.g., they pay 75 percent of charges. Many plans are being written without a deductible.

VISION CARE EXPENSE BENEFITS

Vision care expense is another new and experimental benefit offered by some companies. It provides benefits for expenses incurred for eye examinations, lenses, and frames. An illustrative plan provides payment for one examination and one pair of lenses during any 12-month period and one pair of frames during any 24-month period. Payments are in accordance with a schedule of allowances, such as $10 or $15 for an eye examination by an ophthalmologist or optometrist, $6 or $9 for single vision lenses, $9 or $13.50 for bifocal lenses, and $5 or $7.50 for frames.

CONVERSION PRIVILEGE

If the purchaser desires, companies will include in their policies clauses that give to an individual employee, whose employment is terminated for any reason, the right to obtain an individual hospital-surgical-medical policy carrying specified benefits, at the rate applicable for a person of the employee's sex and age, and without proof of insurability such as is required of other purchasers of individual policies. Such a policy would not exclude pre-existing conditions of any other condition, except possibly maternity, not excluded by the group policy. The addition of a conversion privilege may require a slight additional premium. In New York State such conversion provisions are mandatory.

COORDINATION OF BENEFITS

Many, probably most, group health care policies include coordination-of-benefit provisions. These are intended to prevent an individual who is covered under two group policies (e.g., a working wife who has coverage as an employee and also as a dependent under her husband's coverage, or a child covered under both parent's coverages) from obtaining reimbursement of more than 100 percent of covered health charges, and to provide an orderly manner for determining which insurer will provide benefits in full and which will supplement the other.

The provisions are fairly standard. The following from one policy is illustrative: "They apply when a person covered by this insurance is also covered by some other group plan for which any employer of the enrollee or any person in his family make either (a) contributions towards premium, or (b) deductions from pay or annuity. Benefits are to be coordinated whenever the benefits payable under the two plans would in the absence of coordination provisions exceed allowable expenses.

"In cases necessitating coordination and where the other plan also contains a coordination clause, determination of benefits shall be in accordance with the following rules:

"(a) The benefits of the plan that covers the individual other than as a dependent shall be determined before the benefits of a plan which covers the individual as a dependent.

"(b) The benefits of the plan which covers the individual as a dependent of a male shall be determined before the benefits of a plan which covers the person as a dependent of a female.

"(c) Where rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the individual for the longer period of time shall be determined before the benefits of a plan which has covered the individual for the shorter period of time."

SUMMARY—PLANS OF BASIC BENEFITS

It should be emphasized that the foregoing is intended to describe the more common or typical types of benefits written. Variations and permutations of these plans are available literally without number. Companies will write virtually any plan of benefits that a purchaser desires and for which it can calculate a rate.

Major Medical Plans

As indicated earlier, major medical plans are of two types—"supplementary" and "comprehensive." While both have many variations, they are characterized by two general features—a deducti-

ble and coinsurance. A deductible is considered desirable because it eliminates small claims and confines the insurance to major illness or major expense resulting from a series of illnesses. Coinsurance is considered necessary in order to give the insured an interest in prudent and careful utilization of service and purchase of service at reasonable charges.

SUPPLEMENTARY MAJOR MEDICAL EXPENSE PLANS

Such plans are typically written to supplement a plan of basic benefits consisting of at least hospital and surgical expense coverages. Sometimes the basic plan may include physician in-hospital visits and/or X-ray and laboratory examinations. A supplementary major medical plan may supplement a basic plan written by the same insurance company (much the more general case), a basic plan underwritten by Blue Cross-Blue Shield (less common now than formerly, since most Blue Cross-Blue Shield plans now offer their own supplementary major medical coverages), or a basic plan underwritten by another insurance company. Most companies will not now enter into the last cited arrangement unless they see a chance for the development of additional coverages. Administration of a supplemental major medical plan is much easier and less costly where it and the basic coverages are both underwritten by the same company.

Deductibles and coinsurance.—Typically, supplemental plans pay 80 percent of covered, i.e., eligible, expenses over and above expenses covered under the basic plan and a deductible. The deductible may be of two types: (a) a corridor deductible consisting of the basic plan benefits and a flat amount, typically $100, payable out-of-pocket; and (b) an integrated deductible consisting of basic plan benefits or a flat amount, say, $500, whichever is greater. Under such an arrangement, if the basic benefits payable are, say, $625, the major medical plan pays, say, 80 percent of any excess of covered expenses over $625. If the basic benefits are, say, $400, the plan will pay 80 percent of expenses over $500. The corridor type of deductible is by far the more common.

Under some plans, the deductible is fixed as a certain percentage of the employee's wage or salary or is a fixed amount that increases with the wage or salary bracket of the employee. This is done to achieve equity among employees since it is generally recognized that higher paid employees tend to obtain relatively more in benefits from a major medical plan than lower paid employees. (This results from a number of factors: Higher paid employees tend to utilize more care than lower paid employees; they go to higher priced physicians; they frequently are charged more for the same service; and they are less deterred by the deductible and coinsurance from using certain services such as private duty nursing.)

When dependents are covered, there is a separate deductible for each person. Most plans provide that if two or more persons in a family incur covered expenses because of a common accident, only one deductible need be paid.

Plans are sometimes written with a decreasing coinsurance, such as 75–25 percent of the first $500 of covered expenses exceeding the deductible, 80–20 percent of the next $5,000 of covered expenses, and 90–10 percent of the balance.

Maximum benefit.—All plans cover covered expenses, subject to specified deductible and coinsurance factors, up to a specified maximum benefit—frequently $10,000, $15,000, $25,000, or more. This maximum may be for benefits paid for a single cause or disability or during life of the individual. Where the latter is the case, virtually all plans have arrangements for annual automatic restoration of the maximum benefit once it has been depleted, by crediting to the individual a stipulated amount, say, $1,000 or $2,000 a year, to bring the allowable benefit back to the maximum, or restoration in full by submission of satisfactory evidence of insurability.

Covered expenses.—Almost all plans cover about the same types of medical expenses. Typically, they cover charges incurred for the following types of care:

(a) Hospital care, but with a limit on the daily charges for room and board that may be included. This limit may be a fixed dollar amount or more usually the hospital's average charges for semiprivate accommodations. (It is generally not intended that the insurance reimburse for the extra cost of private or luxury accommodations.)

(b) Physicians' services in the hospital, office, and home, including charges for X-ray and laboratory examinations. Some plans cover physicians' charges for surgery on a scheduled basis, i.e., no

more than a scheduled allowance for each operation will be taken into account.

(c) Private duty nursing by registered nurses in the hospital or home.

(d) Out-of-hospital prescribed drugs and medicines, i.e., drugs prescribed by a physician and obtainable only on a doctor's prescription.

(e) Prescribed appliances (artificial limbs, braces, crutches, etc.) and rental of durable medical equipment (hospital type bed, wheelchair, etc.).

(f) Ambulance to and from hospital.

Items generally not covered are:

(a) Physicians' charges for routine or periodic physical examinations or checkups, including well-baby care, and immunizations.

(b) Dental care, except care required because of an accidental injury.

(c) Eye examinations for eyeglasses, and eyeglasses themselves, except when required because of an accidental injury.

(d) Nursing home care. However, plans increasingly are beginning to cover this type of care on one basis or another. Some cover it on what is called an administrative basis, e.g., they cover it in particular cases, as determined by the insured organization, if it will save hospital costs.

All plans stipulate that charges will be covered only to the extent that they are reasonable and customary. The precise phraseology varies from company to company, but the general import is that a charge is considered regular and customary if it is not in excess of the usual or average charge for such service in the locality, taking into account the nature and severity of the sickness or injury, and the patient's income level. Virtually all plans take cognizance of the sliding scale of medical charges; a charge that might be considered reasonable for a person of high income might be unreasonably high in the case of a person of low or moderate income.

Conditions covered or excluded.—All plans exclude coverage for conditions arising out of or in the course of employment (i.e., workmen's compensation cases), care provided in Federal hospitals, and care for which the patient has no obligation to pay.

Benefits for normal maternity or pregnancy may or may not be provided. If not provided, it is because they are provided under the basic plan. If provided, an extra premium is charged. Most plans have some provision for limited coverage of complications of pregnancy, e.g., extra-uterine pregnancy.

Pre-existing conditions (meaning conditions previously known to the patient and for which he has received treatment) may or may not be covered. Generally they are covered without limitation under policies written on larger groups, e.g., 100 employees or more, and are covered subject to a waiting period in cases involving smaller groups. A usual restrictive provision is exclusion of expenses arising from a sickness or injury that existed (and for which the patient has received treatment) within 3 months of the effective date of the person's insurance, until the end of 3 months during which no charges have been incurred for that sickness or injury, or the elapse of 6 or 12 months during which the person has been continuously insured, whichever comes earliest. Coverage of pre-existing conditions without limitation requires payment of a small additional premium, amounting to 3 or 5 percent of the basic premium.

The great majority of plans today have special provisions as regards charges for treatment of mental illness outside of hospitals. The usual provision is that such expense will be covered only up to 50 percent. In addition, many plans limit covered expenses in such cases to, say, $20 for a physician visit, or place an overall limit, say, $250 or $500, on the amount of the benefits payable, or both. This is intended to prevent the payment of large amounts for psychiatric care or "analysis" of individuals whose mental illness does not require hospitalization and may not prevent them from carrying out their usual work or activity.

All-cause or each-cause basis.—Major medical expense benefits may be written on an all-cause or an each-cause basis. Plans on an all-cause basis are much more popular in terms of number of people covered, are simpler, and give a better overall protection. Such plans will pay, say, 80 percent of covered expenses incurred in a calendar year over and above basic benefits payable and the specified deductible. Under this type of plan, all covered expenses, regardless of cause, incurred during the calendar year are covered. Generally, these plans provide that expenses incurred in the last quarter of the preceding calendar year will be counted toward the current year's deductible.

Under the each-cause plan, only covered expenses arising out of a given injury or sickness,

for which a benefit period has been established, are covered. An each-cause plan may be written on a total disability basis or an accumulation period basis. Under the first, the benefit period for any injury or sickness begins when the insured individual is totally disabled for a period of at least 24 hours. Benefits are payable only for expenses incurred in connection with the disability in question and only after the deductible has been satisfied from expenses for this disability.

Under the accumulation period basis, a benefit period for any injury or sickness begins only when an individual incurs covered expenses during a given period, typically 60 consecutive days (the accumulation period), which are sufficient to satisfy the deductible amount. On either basis, the benefit period terminates after, say, 3 consecutive months have elapsed during which covered expenses of less than $50 are incurred for the injury or sickness in question, or after, say, 3 years from the start of the benefit period, whichever occurs first.

Obviously, the all-cause basis is more favorable to the insured person. Under the each-cause basis a person may incur substantial expenses from a number of illnesses in a given year and yet receive little if any benefits because of the deductible which must be satisfied for each separate disability or illness. By increasing the deductible and shortening the accumulation period, a plan's liability to provide benefits can be greatly reduced.

Extension of benefits.—Virtually all plans provide that when a covered individual's insurance terminates (because of termination of his employment, termination of the group's insurance, or other reason) and he is totally disabled by an injury or sickness as of that date, benefits are extended during continuous total disability for a stipulated period. This typically may be for a year on an all-cause plan or for the benefit period for the disability in question under an each-cause plan, but generally in any case not for beyond a year from the date the insurance terminated.

COMPREHENSIVE MAJOR MEDICAL EXPENSE PLANS

A plan of comprehensive major medical expense benefits is complete in itself and is not written in conjunction with any basic plan. Variations are numerous. A simple type of plan might contain a single deductible of, say, $50, and pay 75 or 80 percent—the latter is the more common—of all covered expenses incurred in a year in excess of the deductible up to a specified maximum benefit amount. There is a separate deductible for each covered person. Most plans provide that expenses incurred in the last 3 months of the preceding year may be counted toward the current year's deductible and require only a single deductible when two or more family members are injured in a common accident.

Among frequent variations is one in which covered expenses are divided into two classes, one consisting of hospital charges for room and board, and the other consisting of all other charges. Thus a plan might pay in full, say, the first $1,000 of hospital charges for bed and board (subject to a maximum of so much per day) and after a deductible of, say, $50 or $100, pay 80 percent of all other covered charges. Alternatively, the plan might pay in full the first $1,000 of all hospital charges, i.e., room and board and the extras, and then pay 80 percent of all other charges in excess of the deductible amount. Or a plan may have a so-called split deductible, i.e., a smaller deductible of, say, $25 for hospital charges and a larger deductible of, say, $50 or $100 for all other charges, with a proviso that in any case the total deductible amount for both types of charges may not exceed the larger deductible. The deductible may vary by wage or salary classes of employees, to offset the fact that a major medical plan pays out relatively more to higher paid than lower paid employees.

Maximum benefit amounts may be $10,000, $15,000, $25,000, $50,000, or more, this being the largest sum that will be paid in benefits for any one covered person during his life. Virtually all plans have provisions for re-establishing the maximum benefit upon presentation of evidence of insurability, or for automatic annual restoration of the maximum benefit when it has been depleted, as described earlier.

Comprehensive medical expense benefits may be written on an all-cause plan or an each-cause plan, and the latter on either a total disability or accumulation period basis. Again, the all-cause plan, in which benefits are paid for all covered expenses incurred during a given calendar year, is the simpler and more generous and it is by far the

more popular plan.

Comprehensive major medical plans cover expenses resulting from an abnormal pregnancy, as defined earlier, and usually, though at an additional premium, cover normal pregnancy cases as well. Usually a normal pregnancy benefit will amount to 100 percent of all charges for pregnancy care without application of any deductible amount, up to a special maximum benefit of, say, $200 or $300, with a larger limit for a caesarean delivery and a smaller limit for miscarriage. Or, less frequently, charges for maternity care are included as covered expenses on the same basis as charges for all other care.

Within recent years some companies have offered dental care expense coverage under comprehensive major medical plans. Such plans have a special deductible for dental expenses of, say, $50, or have a common deductible of, say, $100 or more, for all medical and dental expenses. Special coinsurance and benefit limitations apply. Thus the plan may pay on an 80–20 coinsurance basis for the more common types of dental services—prophylaxis, examination, X-rays, and amalgam fillings, etc., and on a 50–50 basis for inlays, crowns, and dentures. Some plans are scheduled, that is, covered expenses include only charges up to specified scheduled allowances, as set forth in a schedule, for the various services. There is generally a special maximum benefit for all dental benefits, say, $500.

Provisions for conversion privileges and coordination of benefits, similar to those described above under basic benefits, are also commonly contained in supplementary or comprehensive major medical policies.

Premium Rates

It is difficult to give meaningful data on premium rates because of the wide variety of coverages offered, the great number of variations possible within a given coverage, and the variation of initial, i.e., so-called manual, rates in accordance with a considerable number of factors such as sex and age composition of the employee group, its geographical location and industry, the size of the covered group, and the projected premium volume.

The premium rates that companies show in their manuals, have filed with State insurance departments, and quote as initial premiums on a new group are, in a sense, only approximations. Virtually all group business is written on an experience rated basis, meaning that after the first year, by means of rate increases or rate reductions and/or dividends, the rates for each insured group are adjusted on the basis of its experience. In effect the group pays the cost of benefits incurred plus a retention to cover the insurance company's operating expenses and compensation for its risk-taking function.

HOSPITAL EXPENSE

Premiums for basic hospital expense coverage have two main elements—a rate for the daily room and board benefit and a rate for the "other hospital charges." Both of these vary with the content of the benefit, the percentage of women in the employee group, and the group's geographical location.

The process by which an initial rate for a given package of benefits is formulated is illustrated by one company's rate manual, which includes tables by each of seven area "codes" of monthly rates per employee for various combinations of daily hospital benefit rates and days, according to the percentage of women in the employee group. Thus, for an employee group located in Area Code 1 (the lowest cost area), containing 11 to 21 percent women, the premium per employee for a daily benefit of $10 for a maximum of 31 days per confinement is $1.02 a month. For 70 days the rate is $1.09; for 120 days, $1.12. In Area Code 1, the rate for a $10 daily benefit for 31 days duration varies from $0.99 per month per employee in groups containing up to 11 percent women to $1.24 for groups containing 91 to 100 percent women.

The assignment of entire States or specific counties or cities to one area code or another is based upon hospital and medical costs and utilization rates.

The monthly rate per employee for a $10 daily benefit for 31 days for an employee group with 11 to 21 percent women varies in this company's rate table from $1.02 for Area Code 1 to $1.30 for Area

Code 7. Rates for larger daily benefits are almost proportionately higher. Thus the rate for a $30 daily benefit for 31 days in Area Code 1 for a group with 11 to 21 percent women is $3.05.

Quoted rates for dependents do not vary by sex composition. For a $10 daily benefit for 31 days, this same company's monthly rate in Area Code 1 for a single dependent is $1.17, for multiple dependents, $2.15, and on a composite basis, i.e., the rate per employee with one or more dependents, $1.84.

By contrast, the composite rate for Area Code 7 is $2.34.

The monthly rate for the hospital extras likewise varies according to the maximum amount of benefit, the area code, and the percentage of women in the group. For an employee group with 11 to 21 percent women, this company's rate for hospital extras up to a maximum benefit of $100 varies from $1.04 in Area Code 1 to $1.32 in Area Code 7. For a maximum benefit of $700 in Area Code 1 the rate is $2.94. The rate for dependent coverage in Area Code 1 for a $100 maximum benefit is $1.26 for a single dependent, $2.62 for multiple dependents, and $2.18 on the composite basis. For a $700 maximum the composite dependent rate in this area is $5.46.

The above quoted rates for employees and dependents do not include coverage for maternity. For an employee group with 11 to 21 percent women, this company's rate for a flat $100 standard maternity benefit is $0.11 per month, for a flat $500 benefit, $0.42. For dependents on the composite basis, the rate varies from $0.94 a month for the $100 benefit to $3.78 for the $500 benefit. "Immediate" maternity benefits cost more.

To rates thus developed, an age factor based on the distribution of employees by age groups is then applied. This age factor is exceedingly important since the weight for the age group 60–64 is three to four times that for the age group 20–30.

If the industry of the group is regarded as one that is hazardous from a health standpoint, a special loading is then applied. A further adjustment is made to bring manual rates up to current rates based upon estimated increases in cost since the date of the last manual revision.

SURGICAL COVERAGE

The manual premium rates of one company for surgical expense coverage, excluding maternity benefits, for what it calls its standard schedule 3 (1947 Schedule of the Society of Actuaries), which carries a maximum of $200 for any one operation and pays $100 for an appendectomy, ranges in Area Code 1 from $0.56 to $0.83 per month per employee depending upon the percentage of women in the group, and is $0.59 for a group containing 11 to 21 percent women. For an employee group of the same sex composition the rate in Area Code 7 is $0.75. The composite rate for dependent coverage is $1.34 in Area Code 1 and $1.70 in Area Code 7.

For the S–4 schedule carrying a maximum of $240 and paying $88 for an appendectomy, the rate in Area Code 1 for a group containing 11 to 21 percent women is $0.55 per month for the employee and $1.30 for composite dependents; in Area Code 7 the rate is $0.71 per month per employee and $1.67 for composite dependents.

The premium for the S–5 schedule—the California Relative Value Schedule with a conversion rate of $3 per unit, which would pay $120 for an appendectomy—is $0.77 for an employee group with 11 to 21 percent women and $1.78 for composite dependents in Area Code 1. This increases to $0.99 per month for the employee and $2.28 for the composite dependents in Area Code 7. Premium rates for any multiple of these schedules, e.g., 125, 150, or 200 percent, are in the same proportion.

X-RAY AND LABORATORY COVERAGE

For group laboratory and X-ray examination benefits under its scheduled plan, i.e., a plan providing fixed benefits for each procedure, with a $4 conversion factor—which would pay $12 for a chest X-ray, $4.80 for a complete blood count, $12 for an electrocardiogram, and a maximum of $120 for all examinations in a year—this company's rates range in Area Code 1 from $0.19 to $0.26 per month per employee, depending upon the percentage of women. For a group containing 11 to 21 percent women the rate is $0.20. The composite rate for dependents is $0.27. In Area Code 7, the comparable rates are from $0.28 to $0.38 per employee, depending upon the percentage of women, with $0.29 for an employee group with 11 to 21 percent women, and a composite rate for dependents of $0.40 per month.

Under the same company's unscheduled plan,

benefits up to a maximum of $50 are provided in any one year. The rate in Area Code 1 ranges from $0.28 to $0.41 per employee depending upon percentage of women, with a rate of $0.43 for composite dependents. The rate for an employee group containing 11 to 21 percent women is $0.30. This goes up to $0.44 per employee for a similar group in Area Code 7 and to $0.64 for the composite dependent rate.

DOCTOR'S ATTENDANCE EXPENSE BENEFITS

One company's rates for coverage of physician visits in the hospital under a plan paying $3 per day of attendance for up to 31 days per confinement ranges from $0.15 a month to $0.18 a month depending upon the percentage of women in the group. The composite rate for dependents is $0.31. There is no variation by area. The charge for the same benefit for 120 days of attendance ranges from $0.18 to $0.21, with a composite dependent rate of $0.34.

For doctor visits outside of the hospital, on a plan paying $3 per office or home visit, up to a maximum of $150 per year, but with the first three visits in any illness or accident eliminated, the rate ranges from $0.40 per month to $0.59, depending upon the percentage of women in the group, and with $0.42 per month for an employee group containing 11 to 21 percent women. The composite rate for dependents is $1.18. These rates apply under a plan specifying total disability of the employee or the dependent. Under a plan that does not require total disability and pays $2 for an office visit, $3 for a home visit, and $3 for a hospital visit, beginning with the first visit in either sickness or injury, and with a maximum benefit per cause of $150, the rates ranges from $0.74 to $1.08 per month, depending upon the percentage of women in the group. The composite rate for dependent coverage is $1.76 per month. Plans paying higher rates per visit have premiums more or less in proportion.

DENTAL CARE

Dental care coverage, at least where the coverage is reasonably broad, is expensive. One company's monthly rates for a plan paying the lesser of specified schedule allowances or 75 percent of dentist's charges (with allowances of $7.50 for full mouth X-rays, $7.50 for prophylaxis, $5.25 for one surface amalgam filling, $4.50 for extraction with local anesthetic, $39 for full gold cast crown, and $108.75 for full denture, upper or lower) with benefits for periodontia but none for orthodontia, are $3.94 a month for male employee or husband, $4.30 for female employee or wife, and $4.93 for children. The same company's rates for a plan paying dentist's charges up to schedule allowances (with allowances of $15 for full mouth X-rays, $7 for adult prophylaxis, $6 for extraction with local anesthetic, $5 for one surface amalgam filling, $70 for full gold cast crown, and $150 for a full denture) with orthodontia excluded, are $5.19, $5.71, and $6.02, respectively.

VISION CARE

One company's rates for a policy providing $15 for a complete examination (one per person per year), $4.50 for a single lens, $8 for a bifocal lens, and $10.50 for a trifocal one, and $7 for a frame (one per person per 24 months), are in the neighborhood of $1 to $1.15 per employee for employee coverage and $2 to $2.20 for dependents' coverage per employee with dependents.

MAJOR MEDICAL COVERAGE

The determination of premium rates for supplementary or comprehensive major medical coverage is a complicated process. Rates depend upon a considerable number of factors, including percentage of women in the employee group, the age distribution of the employee group, whether the insurance is on an "all-cause" or "single cause" basis, the deductible, the coinsurance factor, the maximum benefit, the income distribution of the employee group, and the area factor (i.e., the rating of the area as regards utilization and medical costs). In the case of supplementary major medical plans, a most important factor is the characteristics of the basic coverage to which the major medical is supplementary; the broader the basic coverage, the lower the rate for the supplemental major medical coverage.

One company cites the rates set forth in table 4–1 as illustrative for various basic benefits, for combinations of basic benefit and supplementary major medical plans, and for one type of comprehensive major medical.

TABLE 4–1.—One company's manual premium rates for typical group medical care coverages [1]

Coverage	Plan specifications	Monthly premium rates: Employee coverage only [2]	Monthly premium rates: Dependent coverage [3]
Hospital expense	Room and board charges up to a maximum $20 per day; maximum of 120 days; no maximum on ancillary charges; excludes maternity coverage.	$4.60	$8.59
	As above, but with room and board charges up to a maximum $35 per day	6.70	12.56
	As above, but with room and board charges up to a maximum $50 per day	8.72	16.32
Surgical operation	Schedule benefits with a $500 maximum; excluding maternity coverage	.91	2.12
Maternity	A flat $300 payment for normal childbirth with increased amounts for caesarean section or operation for ectopic pregnancy and reduced amounts for hospital and surgical services in event of miscarriage.	.11	1.12
Supplementary major medical.	$50 per year deductible, 80 percent coinsurance, maximum of $10,000 in benefits while the individual is insured. (Above plan issued to supplement the second of the hospital expense plans listed above, i.e., $35 per day maximum room and board, and the $500 schedule surgical plan listed above).	1.51	2.48
Comprehensive major	(a) $50 per year deductible, 80 percent coinsurance, maximum of $15,000 in benefits while the individual is insured.	7.87	14.77
	Additional premium for covering maternity the same as any other disability	.52	5.22
	(b) $250 of hospital and surgical operation expenses covered in full, after a $25 deductible, with 80 percent coinsurance on the excess; all other covered expenses subject to $50 per year deductible and 80 percent coinsurance; maximum of $15,000 in benefits while the individual is insured.	9.14	17.37
	Additional premium for covering maternity the same as any other disability	.58	5.7

[1] For a group of typical age, income, and other characteristics.
[2] For an employee group containing 11–21 percent women.
[3] Composite rate, i.e., rate for one or more dependents.

Profile of Group Coverages in Force, December 1966

In 1967 the Health Insurance Association of America made a survey of its member companies to obtain data on the nature and scope of group health insurance coverages in force as of the end of December 1966. This section briefly summarizes the findings of this survey.[4] The data were provided by 56 of the 155 member companies of HIAA that were then writing group health insurance. These 56 companies accounted for 66 percent of the total group health insurance premiums among insurance companies in the United States in 1966.

The companies providing data were asked to give information based on the total policies in force as of December 31, 1966, or a random sample of not less than 10 percent of policies in force as of that date. The sample cases were selected by the company but were to be representative as regards types of coverage, levels of benefits, size of group, and geographical location of insurance. The data were to be confined to persons under 65 years of age. In considering the data it should be borne in mind that benefit levels have increased since 1966.[5]

The recent annual surveys of the HIAA indicate that under group insurance policies the number of persons with major medical expense coverage is equal to about three-fourths of the total number with some hospital or surgical expense coverage.[6] The survey asked for data on (1) the general nature and scope of major medical expense coverages and (2) policies providing basic coverages of hospital and surgical expense *where the policies were not supplemented by major medical coverages.*

SUPPLEMENTAL MAJOR MEDICAL EXPENSE BENEFITS

At the end of 1966, 39 million persons under age 65 were covered by group supplemental major medical policies. About three-fifths of these people were covered by "all-cause" plans and two-fifths by "each-cause" plans. Over two-thirds had maximum benefits of $10,000 or more. Approximately 70 percent of the persons covered (i.e., employees and dependents) had a corridor deductible of $100 (i.e., basic benefits plus $100), 12 percent had a smaller deductible than this, 15 percent a larger

[4] Health Insurance Association of America, *A Profile of Group Health Insurance in Force in the United States, December 31, 1966.*

[5] Since the data were based largely on sample cases selected by each company and since in general the companies would desire to "put their best foot forward," it is possible that the survey results present a somewhat more favorable picture than actually existed.

[6] The number with supplementary major medical coverage includes some where the coverage supplements Blue Cross-Blue Shield basic benefits.

one, and 4 percent of those covered had other types of deductibles.

Ninety-four percent of the persons covered had a corridor deductible; 4 percent an integrated deductible, usually $500; and 2 percent had other types of deductible arrangements. About two-thirds had a coinsurance arrangement of 80–20, with 18 percent having 85–15 or 90–10, and 13 percent, 75–25. More than nine-tenths had benefits for nervous or mental disorders; half of these had full benefits while in the hospital and reduced benefits out of the hospital; about a fourth had full benefits whether or not hospitalized.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

Nearly four-fifths of the people covered under comprehensive major medical expense benefits were under an "all-cause" plan, the remainder being under an "each-cause" plan. More than nine out of every 10 insured had a maximum benefit of $10,000 or more. One-fourth had a maximum benefit of $20,000 or more.

Of the total persons covered, 37 percent were covered under policies that had a single overall deductible, which in 80 percent of the cases was $50 or less; 21 percent had no deductible for hospital expenses, but a deductible for other expenses, which for about one-third of those covered was $50 or less; 28 percent had one deductible for hospital-surgical benefits and a different deductible for other expenses; and 14 percent were under policies providing other arrangements.

Ninety-three percent of the persons insured were covered under policies that had a coinsurance ratio of 80–20, 4 percent had a coinsurance arrangement of 75–25, and the remainder had other coinsurance arrangements.

About two-thirds of the people covered by comprehensive major medical expense policies had some full payment area of medical expense, this full payment area being generally for hospital expenses or hospital and surgical expenses. About 96 percent of the people covered had benefits for nervous or mental disorders and 75 percent of these were eligible for full benefits while in a hospital and for reduced benefits while out of a hospital.

BASIC HOSPITAL-SURGICAL-MEDICAL EXPENSE BENEFITS

The data from this point on relate solely to persons covered by basic plans with no major medical expense coverage. The 16 million people covered by such policies at the end of 1966 were about one-fourth of those covered under group health insurance policies of insurance companies.

Hospital expense.—Of all the persons covered, 34 percent had a maximum duration of hospital benefits of 31 to 69 days (mainly 31 days); another 34 percent had a benefit duration of 70 to 119 days (mainly 70 days); and the remaining third were covered for 120 days or more. Nineteen percent of the total were covered for 365 days.

Of the total, 12 percent were covered for daily room and board benefits of less than $12 a day, 32 percent for benefits of $12 to $17.99, 24 percent for benefits of $18 to $23.99, 11 percent for benefits of $24 or more, and 18 percent for semiprivate accommodations, with 3 percent having other benefit arrangements. Of all covered employees and dependents, approximately 14 percent were eligible for reimbursement of ancillary hospital expenses up to a maximum of under $200; 33 percent to a maximum of $200 to $399; 17 percent to a maximum of $400 to $999, 30 percent to a maximum of $1,000 or more, and 6 percent were covered under other arrangements.

Surgical expense.—Thirty percent of the persons insured for surgical expense had a benefit maximum of less than $300, 36 percent had a maximum between $300 and $349, 20 percent had maximums ranging between $350 and $500, and the remainder had higher maximums, including those written on a "reasonable and customary charge" basis. Approximately 45 percent of the total were covered by policies that had schedules based on the 1947 Society of Actuaries Schedule, another 20 percent on the 1957 Society of Actuaries Schedule, 4 percent on the California Relative Schedule, and 31 percent on other schedules.

Of those with nonsurgical medical expense benefits, 81 percent were covered for physician visits in the hospital only, 16 percent for visits in the hospital, office, and home, and 3 percent for various other combinations. Of those with coverage for doctor in-hospital visits only, nearly one-third were entitled to benefits payable for up to 31 days, over one-third for benefits for 32 to 70 days, and an additional one-fifth for 71 to 120 days of bene-

fits. About 1 in 10 were covered for 120 days or more of doctor visits.

Benefits for in-hospital visits were generally provided from the first day of hospitalization. Twenty-six percent of the persons with in-hospital benefits were covered by plans paying $3 a visit, another 28 percent by plans paying $4 a visit, 37 percent by plans paying $5 a visit, and 9 percent by plans paying $6, $7, or more a visit.

About one-third of the plans covering physician visits in the office and home provided protection from the first day of accident or sickness. Forty-seven percent paid $3 a visit, 13 percent $4, 26 percent $5 a visit, and the remainder other amounts or different rates for office and home visits, etc.

OUT-OF-HOSPITAL DIAGNOSTIC X-RAY AND LABORATORY EXPENSE

Approximately 80 percent of the persons with nonsurgical medical expense coverage under group policies were covered for out-of-hospital X-ray and laboratory examination expenses. Of those with this coverage, over three-fifths were protected on a nonscheduled basis. Under the unscheduled plans, 17 percent of the persons covered were insured for maximum benefits of less than $49 and 47 percent for maximums of between $50 and $74. Under the scheduled plans, 23 percent were covered for maximum benefits of less than $50, and 44 percent for maximums between $50 and $74.

Government-Wide Indemnity Benefit Plan for Federal Employees

As was done earlier for Blue Cross and Blue Shield, it seems desirable to illustrate the benefits offered by insurance companies under their more comprehensive plans by citing the benefits made available under the high option of the Government-Wide Indemnity Benefit Plan, one of the plans offered to Federal employees under the Federal Employees Health Benefits program. This plan is offered by a consortium of insurance companies under the management of the Aetna Life Insurance Company, and is commonly known as the Aetna Plan. In its high and low options, it has been chosen by some 530,000 Federal employees and annuitants, a little more than one-fifth of all such persons. Including dependents, the total number of persons covered under the plan is in excess of 1,500,000. This group constitutes probably the largest single group insured for health benefits under any group plan offered by an insurance company. About three-fourths of the Federal employees and annuitants covered by this plan have selected its "high option" which is here described, as of 1968.

The plan pays 100 percent of the first $1,000 of allowable expense for hospital room and board (no charges in excess of those for semiprivate accommodations are allowable) in each calendar year, plus 80 percent of any balance. For other hospital expenses and surgical and medical expenses, it pays 80 percent of allowable expenses over the first $50 in each calendar year with a proviso that not more than $25 of this $50 deductible will be charged against other hospital expenses. For maternity, the same benefits are provided as for all other conditions. Family expenses exceeding $10,000 in a calendar year are paid in full. The maximum lifetime benefit is $50,000 per person, with an automatic annual restoration of $2,000 per person.

The plan has no schedule of fees or allowances, but pays benefits for allowable charges to the extent that they are reasonable and customary. Whether a particular charge is reasonable and customary is determined by comparing it with charges ordinarily made for a similar service or supply provided under similar conditions to people in like circumstances.

"Other hospital" expenses include charges for services and supplies other than room and board furnished by a hospital for treatment in the hospital or its outpatient department. Surgical and medical expenses include the professional services of doctors in the office, home and hospital; the professional services of registered nurses; diagnostic X-ray, laboratory, and other tests; anesthesia; oxygen; blood (not donated or replaced, etc.); surgical dressings; rental of durable medical equipment; professional ambulance service to the first hospital where treated and from the hospital to the home if required by the patient's condition;

drugs and medicines that may be purchased only upon a doctor's prescription; appliances; braces, etc. Hearing aids and examinations therefor and eyeglasses and examinations therefor are provided if required because of an injury due to accident. Likewise, dental care required for an injury resulting from an accident is covered. Services of a Christian Science practitioner are covered if such services are elected for a given year instead of the services of a doctor of medicine.

Excluded from coverage are charges for dental care (other than care required because of an accident), charges for routine physical checkups, routine well-baby care, immunizations, routine eye examinations for eyeglasses, and eyeglasses and hearing aids.

The amount of the deductible, as already stated, is $50 per person. However, after three covered persons in a family meet the deductible in any calendar year, the deductibles for the remaining covered persons in that family are waived for expenses incurred during the balance of that calendar year. Expenses incurred and actually applied toward the deductible of the enrollee or one of his family members during the last 3 months of a calendar year may also be applied toward the deductible for that person for the following year.

Benefits for mental and nervous disorders for a person who is not a hospital inpatient are limited to 50 percent of the allowable expenses or to $250 per person during each calendar year, whichever is less in benefits, for the charges for professional services, day care, and prescribed drugs.[7]

The monthly cost of the Aetna High Option Plan in 1968 was $11.70 for "self only" coverage and $29.03 for "self and family" coverage. This cost was increased to $15.21 and $37.72, respectively, beginning January 1, 1969. Both sets of figures include the Government contribution of $3.64 for the employee or annuitant by himself and $8.88 for the employee or annuitant and his family.

Summary

The majority of persons covered under group health insurance policies of insurance companies have either basic benefit coverages supplemented by major medical coverages or single package comprehensive major medical coverages. Actually, the difference between the two tends to be fuzzy since comprehensive major medical coverages frequently have areas of first dollar coverage of hospital expense.

Most of the persons with major medical coverage have some protection against practically all types of health care expense, other than those for dental care, eyeglasses, routine health checkups, and nursing home care. The coverages almost universally apply against all types of illnesses, including mental illness and in all types of hospitals; however, the degree of protection generally is reduced or restricted as regards care of mental illness outside the hospital.

Any judgment as to the depth and adequacy of this protection depends upon the point of view and the standards of appraisal used. In general, the coverages do not encourage preventive health care and care early in illness, since charges for immunizations and health checkups are specifically excluded and charges for physician office and home visits are generally covered only after a certain amount of expense has been met out of pocket. Once the deductible has been satisfied, the payment by the insurance of, say, 80 percent of the cost encourages people to obtain needed care.

The extent to which these coverages give protection against catastrophic or burdensome illness expense depends in part upon the income level of the insured. An expense that is catastrophic for a family living on $6,000 a year may be serious but not overwhelming for families with twice that income and quite minor for those with four times that income. In very costly illnesses, the unreimbursed 20 percent of total charges may be a catastrophic cost for some. When account is taken of the initial deductibles that must be paid under these coverages, of the fact that several members of a family may have serious sickness in the course of a year with a deductible having to be satisfied in each case before the protection takes hold, and of the existence in some plans of a deductible for each separate illness, a family can sometimes have quite

[7] This limitation on out-of-hospital benefits for mental and nervous disorders was removed, effective January 1969.

heavy illness expense in the aggregate and nevertheless have very little of it covered under this insurance.

For those who are without major medical coverage of any sort, the protection provided by basic benefit coverages is largely focused on hospitalized illness. (However, large numbers of people do have some coverage—though mainly rather meager—of charges for out-of-hospital X-ray and laboratory examinations.) The extent to which these basic coverages meet the charges for hospitalization, surgery, and in-hospital physician visits varies widely.

A significant volume of dental care coverage is being written, and some companies are beginning to offer basic coverage of drugs, home health services, and vision care.

Group policies vary widely in the extent or effectiveness of the coverage provided. One indication of this is shown by the relationship of the premium income per person covered under the high option of the Government-Wide Indemnity Plan for Federal Employees, which in 1967 was $92.52, to the premium income under all group policies per person covered for hospital benefits, which in 1967 was $59.75. In other words, the relatively comprehensive high option plan for Federal employees provides a 50 percent better coverage, overall, than the average group policy—or at least has the wherewithal to do so.

In view of the importance of major medical coverages under group health insurance, mention should be made of one aspect of these coverages that may become a problem in the future. All of these coverages provide reimbursement of, say, 75 or 80 percent of charges incurred, to the extent that these are usual, customary, and reasonable. As this type of insurance grows along with other programs—Blue Shield prevailing fee programs, the Federal Government's Medicare and some State Medicaid programs—which have similar arrangements, it is possible that a point may be reached at which charges not paid or reimbursed by insurance will cease to provide a standard of "usual, customary, and reasonable" charges. In other words, the growth of insurance providing for payment on this basis may reach a point at which it fails to provide effective control over charges, giving rise to a situation in which providers of service may profit unduly at the expense of insureds.

Chapter 5

INSURANCE COMPANIES—INDIVIDUAL POLICIES

Almost a thousand insurance companies write individual health and accident policies. While some of these companies restrict themselvess to disability or accident coverages, the majority write medical expense coverages. Of the latter, the larger companies write several medical expense policy forms—some 10 or more—all or most of which have variable elements, e.g., different daily benefits for hospital room and board, different amounts payable for other hospital expenses, different surgical schedules, various riders, etc. The resulting profusion of policies and permutations and combinations thereof is such as to permit description only in general terms and by citation of illustrative policies. The following description, which pertains only to policies offered to persons under age 65, is based on copies of typical policies, promotional material and sales manuals supplied to the Office of Research and Statistics by the nine largest writers of individual hospital-medical expense insurance. These companies probably write about 40 percent of the total volume of this type of insurance.

The benefits under individual policies are, in general, similar to those offered under group policies, but with the following major differences:

(1) The benefits tend to be less broad. One reason for this is the high expense of selling and administering this type of policy. (For all individual health insurance, selling and other operating expenses and net profit accounted for 47 percent of premiums in 1967.)[1] As a result the benefits that can be offered for a given premium are much smaller than under group policies. In 1967 estimated annual benefit expenditures per covered person under individual policies were $16.12 for hospital care and $5.04 for physician service, compared with $33.06 and $18.46 under group policies.[2] Furthermore, no employer contributions are available under individual policies.

(2) A significant proportion of all individual policies are sold to people who have other coverage—group or individual—and who purchase it in order to supplement these other coverages. Probably at least 25 percent of the holders of individual policies have other protection.

(3) Within recent years there has been a considerable sale (and not only among older people) of coverages that provide a fixed benefit per day or week, e.g., $100 per week, of hospital confinement. (Although policies of this sort have been available for many years, their sale was considerably spurred by the advent of Medicare when many companies offered policies of this type to older persons to complement Medicare benefits; since then they have been widely sold to persons under age 65.) These policies, by themselves, obviously offer relatively little protection against hospital costs and are largely purchased to supplement other coverages.

(4) Coverages of the major medical type are relatively much less numerous under individual than group policies. In 1967 persons with major medical coverage under individual policies accounted for only 13 percent of those with some hospital coverage, whereas under group policies of insurance companies the proportion was 78 percent.[3]

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[1] Louis S. Reed and Willine Carr, "Private Health Insurance in the United States, 1967," *op. cit.*

[2] *Ibid.*

[3] Some of those with group major medical coverage have it as a supplement to Blue Cross-Blue Shield but allowance for this would not materially affect the contrast.

(5) Exclusion of, or restrictions on, coverage of various conditions and diseases is much more common under individual than group policies. These grow out of the need of insurers to protect themselves from adverse selection of risks.

Individual policies are generally sold on a basis that permits the company to select its risks.[4] The company may refuse an applicant whose health history, as shown by responses on the application form (physical examination of applicants for hospital-medical insurance is uncommon), indicates that he would be a poor risk, or it may accept him subject to a waiver of coverage for certain conditions. Some companies will accept substandard risks at a higher premium.

The provisions for cancellation and renewal are an important feature of individual policies. Very few policies are now issued under which the company has the right to cancel the policy at any time. Such policies have been generally recognized as unfair to the insured and are prohibited by law in many States. As regards renewal, the policies fall into four classes: (1) Renewable at the option of the company, i.e., where the company may refuse to renew the policy of a particular individual; (2) conditionally renewable, i.e., where the company may refuse to renew a policy for certain reasons stated in the policy, not including deterioration of health of the insured individual, or may refuse to renew all policies of this class; (3) guaranteed renewable, i.e., where the company guarantees to renew the policy (at least up to a stated age, generally 60 or 65), but reserves the right to increase the premium provided such increase applies to all policies of like class or to all of such policyholders resident in a particular State; and (4) guaranteed renewable at guaranteed premium (called noncancellable), i.e., where the company guarantees to renew at fixed premium.

Although probably most policies currently in force are of type 1, probably the majority of those being sold today are of types 2 and 3, with the greater part being of type 3. Relatively few medical expense policies are of type 4, since the rapid increase in hospital and physician charges makes it impossible for a company to estimate its future obligations. The policies providing a fixed benefit (e.g., $100 a week) during hospital confinement are an exception; some of these are issued at guaranteed premiums for life.

Provisions for cancellation or renewal are significant since they determine the long run value of the coverage. The value of coverage to an individual is much impaired if, following a claim in a serious illness, the company cancels the policy or at the next renewal date refuses to renew at all or renews subject to waiver of coverage for one or more specified conditions.

Policies providing basic benefits, major medical benefits, and fixed hospital benefits will be described in order.

Basic Benefit Plans

The basic benefit policies offer first dollar coverage of medical care expenses, generally without deductible or coinsurance features. Such policies often provide hospitalization and surgical expense benefits only; there is relatively little coverage of physicians' in-hospital visits, and very little of physicians' office and home visits, although policies with these coverages are readily available.

HOSPITAL BENEFITS

Coverage of expenses for general hospital care is provided up to a specified number of days—commonly 30, 70, 120, or 180 days—per illness or injury. A growing number of companies offer policies providing benefits up to 365 or more days per condition. Provisions for periodic increments in the duration of benefits are sometimes made. One policy, for example, increases its 100-day maximum benefit period by 10 days for each 12 consecutive months that the policy is in force until a total period of 200 days has been reached. Most policies specify that a period of 6 months must separate confinements, due to the same or related causes, before renewal of benefits.

Daily allowances for room and board during the covered period of confinement may range from as little as $6, $8, or $10 per day to $35, $40, or $50 per day. Some contracts allow twice the applicable

[4] Some companies sometimes offer for a limited period to accept all persons of a given age group who enroll prior to a given date. However, such acceptance of persons regardless of state of health is an exception to the rule.

room and board indemnity when an intensive care unit is used. Under some family policies the allowances are smaller for covered dependent children than for adults. The daily room rate has added significance since, as will be seen later, many other benefits are defined in relation to this allowance.

Almost all policies cover other hospital expenses, i.e., use of operating room, X-ray and laboratory examinations, anesthesia services and materials, oxygen, blood transfusions, medications and supplies, etc. Benefits for these other services take several forms. Some policies provide payment up to an overall limit ($300, for example). Some set this limit at a multiple of the daily room and board benefit, e.g., 10 times, 20 times. Some specify payment of, say, 75 or 80 percent, with or without a deductible and up to a specified maximum. Some policies provide payments up to specified amounts for each specific service. Thus one policy, for example, allows $20 for anesthesia, $10 for X-rays, $7.50 for laboratory and pathology services, $15 for medicines, $15 for oxygen equipment and supplies, and $25 for blood transfusions. Such internal limits are, of course, much less favorable for the policyholder than a single maximum for all services.

The great majority of policies define "hospital" in such a way as to exclude coverage in convalescent or nursing-home facilities. A few policies do, however, include benefits for skilled nursing-home care. Most frequently confinements in a nursing home are only covered if they follow, within a specified period, discharge from a general hospital and are due to the same or related cause as the previous hospital stay. A 60-day period of coverage is common and benefits are often limited to one-half the regular hospital daily room and board maximum.

Universally, policies define hospitals so as to exclude places for treatment of alcoholics or drug addicts.

SURGICAL BENEFITS

Individual and family policies covering basic surgical expenses provide for reimbursement of these expenses in accordance with a schedule set forth in the policy. Various schedules are offered, scaled in proportion to the largest amount payable for any single procedure. These maximum surgical allowances for a single procedure are generally in the range of $200 to $700.

Limits on the dollar maximum payable for all surgical procedures performed during any one confinement are sometimes specified. In most cases confinement to a hospital is not required as a condition for payment of surgical benefits.

PHYSICIANS' VISITS

There is less coverage for physicians' visits (other than for surgery or obstetrics) than for hospitalization and surgical benefits. Surveys indicate that the number of persons covered for physicians' in-hospital medical visits under all individual policies is only one-third the number covered for hospital benefits.[5] In-hospital visit allowances may be in the form of a daily benefit, e.g., $3, $5, or $7, for a specified number of days, or up to a specified dollar limit. The number of days of benefits and amount paid per day vary widely.

When physicians' visits in the office, clinic, and home are covered, the benefits are generally in the range of $3 to $7 per visit. Benefits generally begin with the first visit for accident or injury, but on the second or third visit for illness, and are usually limited to one visit per day. Those policies that cover all physicians' visits generally put a limit on the amount of benefits payable, commonly $200 to $400 for any one illness.

MATERNITY BENEFITS

Many basic individual and family policies exclude coverage of maternity expenses. Those that do offer benefits for maternity do so only after a waiting period of 9 or 10 months. Payment is most often made on the basis of a maximum maternity allowance for all covered services received (hospital and professional). Typical allowances are $100, $150, and $200 per pregnancy in normal deliveries. Sometimes the benefit is a specified multiple—five or 10—of the regular daily room and board rate.

Frequently, maternity benefits are the same for complications of pregnancy as for a normal delivery. However, some policies do allow additional

[5] Louis S. Reed and Willine Carr, "Private Health Insurance in the United States, 1967," *op. cit.*

payments for complications of pregnancy, while other policies that exclude coverage of normal delivery cover specified complications of pregnancy to the same degree as other covered conditions. In cases where normal maternities are covered, any benefits received are in lieu of all other benefits covered by the policy.

OTHER BENEFITS

Relatively few basic individual policies go beyond the hospital, surgical, and medical benefits outlined above. When they do, it is generally to provide benefits for ambulance service, emergency accident and first aid care, and out-of-hospital X-ray, laboratory, and radiotherapy services. Ambulance expense benefits range from $15 to $25 per accident or illness. Emergency accident expenses incurred by persons who are not hospitalized are generally payable up to a stated maximum such as $10 or $25 per accident. Some first-aid benefits following accidents are payable in amounts that are limited to one and one-half or two times the daily room and board rate. Payment for out-of-hospital X-ray and laboratory examinations and for radiotherapy is generally according to scheduled allowances listed in the policies.

Only rarely do the basic policies cover such services as special duty nursing in the home or hospital, or prescribed drugs and medications outside the hospital. From among the few that do cover these latter services two examples are instructive. One policy offers the following benefits for special duty nursing services. When the services of a graduate registered nurse are required for hospital inpatients as a result of accidental injury, the company pays up to $10 per day for 10 days per accident. In addition, nursing services in the home are covered and payable in amounts not to exceed the daily room and board rate for 30 days for each illness or injury. A policy of another company covers out-of-hospital prescribed medicines and surgical dressings. Payment for these items is made up to an aggregate amount of $35 after a $10 deductible in each illness. An iron lung benefit of $150 for out-of-hospital patients is another example of a less frequently covered service.

EXCLUSIONS AND LIMITATIONS

All or virtually all policies exclude pre-existing illness, either permanently by specific mention in the contract (based upon the applicant's disclosure of previous treatment for this condition), or during the first 2 years of coverage. The terminology varies. A common wording is that the policy covers only sickness "contracted while this policy is in force." Such a provision would enable a company to reject a claim for benefits for an illness, e.g., cancer, which had its inception before the taking out of the policy, but of which the insured was unaware at the inception of the policy. An alternative wording, more favorable to the policyholder, defines pre-existing sickness as "sickness or injury which first manifests itself or is medically treated prior to the policy date and disclosure of which is requested on the application."

Virtually all policies cover pre-existing conditions (unless it be a condition disclosed in the application and specifically waivered in the contract) after 2 years. This is in accordance with a provision in the Uniform Individual Accident and Sickness Policy Provisions Law, sponsored by the National Association of Insurance Commissioners and the insurance companies, which requires each policy to contain the following provision (or a provision no less favorable to the policyholder): "No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy." All States have adopted the Uniform Provisions law; some specify a 2-year rather than a 3-year period in the provision.

Many policies provide that benefits will not be provided for sickness contracted prior to 30 days after issuance of the policy (although accidents are covered from the inception date). The great majority of policies exclude all coverage for mental illness, or provide benefits for a much shorter period than for general illness. If covered, most provide benefits in both general or mental hospitals. Care paid for by workmen's compensation is always excluded.

Many policies have a waiting period—frequently 6 months—for benefits for one or more specified conditions or diseases. Conditions frequently so restricted include hernia, hemorrhoids, tonsil and adenoid removal, and conditions of the female generative organs; less commonly, appendi-

citis, cancer, heart disease, and diseases of the circulatory system may be included. Cosmetic surgery is generally excluded except when necessary for the correction of damage caused by accidental injury while the policy is in force or to correct congenital malformations of covered newborn infants.

A few individual policies provide that when benefits for an illness or accident are payable under other policies or plans, and if the aggregate benefits would exceed the expenses incurred, the insurance policy in question will reduce its payment pro rata. This will be discussed in more detail later.

ILLUSTRATIVE POLICIES

The following summary of the benefits and premiums under two illustrative policies of major carriers may help to give a better understanding of the situation.

Policy A provides daily room and board benefits for up to 365 days for any one illness or injury. Various plans are available with daily benefits ranging from $10 to $50 a day for adults, slightly less for children. "Other hospital expenses" (not including radiotherapy) are covered up to maximums of $150, $225, or $300 for adults, and slightly less for children. Surgical expenses are reimbursable according to schedules with maximum allowances of $400, $500, $600, $700, and $800. Doctors' visits in the hospital will be paid for at amounts ranging from $3 to $9 per day for a maximum of 31 days. Allowances for normal maternity care are $100 or $150. Radiotherapy benefits in or out of the hospital are also available.

Pre-existing conditions, manifested before inception date, are excluded for 2 years. Benefits for neuropsychiatric disorders are limited to 30 days per confinement. There is a waiting period of 6 months for benefits for hernia, removal of tonsils or adenoids, and treatment of female genital conditions.

For a plan providing a daily room and board benefit for adults of $30, and for children (under age 18) of $24, a maximum for other hospital services of $300 for an adult and $240 for a child, surgical expense indemnity on the $800 schedule (provides $240 for an appendectomy), maximum daily benefit for physician attendance in hospital of $9 for 31 days, and a $150 normal maternity benefit, the annual (level) premiums are as follows:

Age at issue	*Husband*	*Wife* [1]
25–29	$92.95	$170.50
30–34	108.35	170.50
35–39	118.80	170.50
40–44	129.80	170.50
45–49	145.75	170.50
50–55	159.50	181.50

Each child, 0 to 18 years, $54.45.

[1] If the husband is living and not covered and the wife is between the ages of 25 and 44, $15.40 is added to the wife's annual premium.

The policy is guaranteed renewable to age 65, when eligibility for Medicare becomes effective. The company, however, retains the right to change premium rates on all policies in this class.

Policy B, issued by another major carrier, is available in a great variety of plans. All provide benefits for persons under age 65 for up to 500 days for any one sickness or accident. Sickness means sickness "contracted while the policy is in force." For hospitalization for mental illness, benefits are limited to the applicable daily benefit for up to 30 days for any one disorder. For childbirth occurring 10 months after policy date, or for premature birth, miscarriage, etc., providing that a full-term pregnancy would have occurred 10 months after said date, the policy pays up to five times the combined daily benefit for the insured and spouse.

Daily room benefits ranging from $5 to no stated maximum are available. Six different plans providing payment of "other hospital expenses" are offered. One pays up to $230 for covered expenses on an allocated basis; another pays the first $100 of such expenses and then 80 percent of the excess up to a total of $1,000; another pays 80 percent of such expenses in excess of $100 and up to a total of $1,000; another pays 80 percent in excess of $250 up to same limit; another covers up to $100; and the last covers up to $250 on an allocated basis and then 80 percent of excess up to $1,000. Four surgical expense riders are available with maximum allowances ranging from $225 to $600. Also available are two plans for in-hospital medical visits paying, respectively, $3 and $5 a day, up to a maximum in both cases of $500. Riders providing hospital outpatient benefits, convalescent or nursing-home benefits, and dental care benefits are available.

The policy is guaranteed renewable for life, subject to the right of the company to change premiums for all policies of this form issued to persons of like classification in the same State.

Premiums for each plan or level of benefit vary by age at issue and sex. For the following package of plans, the annual rates for an adult man and woman, both aged 30 to 34, and a child, under age 18, are as follows:

	Man	*Woman*	*Child*
Hospital expense:			
$30 daily room benefit	$60.00	$70.80	$30.00
Other hospital expenses—pays first $100 and then 80 percent of excess up to a total of $1,000	26.76	33.76	14.16
Surgical expense—$600 maximum (pays $220 for an appendectomy)	23.20	36.64	19.60
In-hospital medical visits—$5 a day	4.12	5.12	2.80

The total for a family with two children would be $375.52.

Major Medical Policies

Individual policies providing benefits along major medical lines are similar to group major medical policies. The line between supplementary and comprehensive policies becomes fuzzy, since a policy with a large deductible, say, $500, can stand alone or, in effect, supplement a low-level basic benefits coverage of the same company or another carrier or plan.

Eligible expenses are generally the same as under group major medical policies (convalescent or nursing-home care expense may or may not be included). The policies generally pay 75 or 80 percent of covered expense in excess of a deductible; some have seperate deductibles for different expenses. Most policies provide benefits on a one-cause basis, i.e., they cover expense from one sickness or injury in excess of a deductible (deductible must be satisfied by expense incurred within a given period, say, 1 year) and incurred during a given benefit period, say, 2 years, from the time expense was first incurred for this illness. Only a minority of policies provide benefits on the basis common under group major medical policies, i.e., pay a specified percentage of all illness expense incurred within a calendar year that is in excess of a specified deductible. (This basis is more favorable to the policyholder than the other.) Maximum benefits tend to be lower than under group policies—frequently the maximum benefit under individual policies is no more than $1,000, $2,000, or $5,000. However, policies are available with maximums of $10,000 to $20,000 or higher. Some illustrations are in order.

Policy C offers what is in effect basic hospital-surgical benefits coverage with supplementary major medical. The basic plan provides daily hospital room and board benefits ranging between $8 and $40 for 100 days, allocated benefits for "other hospital services," i.e., $35 for operating room, $35 for anesthetics, $10 for ambulance service, $25 for drugs, $10 for laboratory examinations, $25 for X-rays, electrocardiogram, and basal metabolism rate tests, $25 for blood or blood plasma, $25 for oxygen, and $100 for iron lung, and pays for surgery in accordance with a schedule providing a $225 maximum.

The policy excludes sickness contracted prior to 30 days after date of issue; excludes mental illness and alcoholism; and has a 6-month waiting period for benefits for abdominal hernia, tuberculosis, heart disease, hemorrhoids, removal of tonsils or adenoids, appendicitis, or diseases of the generative organs.

The supplemental major medical rider pays 75 percent of the expenses incurred for "other hospital services" and surgery not met by the basic benefits in any one illness during a 2-year period, up to a total of $5,000. It pays nothing for hospital room and board and provides no benefits for physician visits, out-of-hospital drugs, appliances, etc. Major medical benefits are prorated in event of duplication of valid coverage with other insurers or service plans of which the company has not been informed in writing at time of policy issuance.

The policy is guaranteed renewable, subject to change of premiums for all policyholders of this form in the State. Monthly premiums for the basic plan with a $30 daily room benefit are $10.70 for a man between age 30 and 39; $15.95 for a woman of the same age, and $4.35 for a child under age 17. There is a $12 enrollment fee. The major medical rider costs $2.50 a month for a man and $3.60 for a woman between the ages of 30 and 39, and $0.90 for a child under age 17, with a $6 enrollment fee.

Policy D is illustrative of a comprehensive major medical plan with a large deductible. There is no basic coverage. The policy pays 80 percent of eligible expense from a given illness or injury in excess of a deductible of $500, and up to a maxi-

mum of $10,000.[6] The benefit period is 2 years and the deductible must be met by expense incurred within the first 90 days of the benefit period. Eligible expenses include hospital room and board up to $30 a day; other hospital services; convalescent or nursing-home room and board up to $15 per day for a maximum of 60 days (confinement must start within 7 days of a continuous hospital stay of at least 5 days); ambulance services; private duty nursing in the hospital; medical care by a physician; surgical service up to specified maximums for each procedure; 50 percent of charges for private duty nursing care provided outside the hospital; anesthesia service; X-ray, laboratory, and radiotherapy; and medical supplies and equipment, such as drugs, braces, artificial limbs, and rental of a hospital-type bed, wheelchair, etc.

Exclusions are sickness contracted and commencing prior to the effective date, and maternity care other than certain unusual complications of pregnancy. Mental illness is covered only in the hospital and the maximum benefit is only half that for other illnesses. There is a 6-month waiting period before benefits are payable for hemorrhoids, conditions of the female generative organs, repair of hernia, removal of tonsils or adenoids, and removal of appendix concurrent with an operation on the female generative organs.

The policy is guaranteed renewable to age 65. For a man aged 35, with a wife aged 30 and two children, the annual premium is $157.60 plus a single extra premium of $15.

Fixed Weekly Benefit Hospital Policies

Within the past 4 or 5 years there has been a wide sale of individual policies providing fixed benefits per week or day of hospital confinement. Policies are offered providing weekly payments of $50, $100, $150, $200, or $250 (daily benefits are one-seventh of these amounts) for 52 or more weeks of hospital confinement for each sickness or accident. If the 52 weeks of benefits are used and the same condition returns, a new 52-week benefit period will be provided if 6 months has elapsed between confinements.

Policies of this type are offered on the assumption that the purchaser will use the protection to augment that provided under other health insurance coverages. The advertising emphasizes that benefits are payable regardless of coverage under other private insurance or Medicare and may be used for expenses not covered by other insurance, to pay home expenses or to supplement income while hospitalized.

Most frequently, confinements for maternity care are not covered. A few policies do offer limited benefits of $50 to $100 which cover maternity care in lieu of the regular weekly or daily cash indemnity. Other limited maternity benefits may be set at 50 percent of the regular indemnity allowances.

Generally benefits are not provided for hospitalization for treatment of mental disorders. A few policies provide benefits for 30 to 45 days during any one continuous period of inpatient treatment for mental disorders. Confinements in nursing homes or convalescent facilities are not covered.

An illustrative policy offered by one large company provides lifetime benefits ranging from $50 to $150 per week if the beneficiary is continuously confined in a hospital. The policy defines hospitals so as to exclude care in convalescent homes, nursing homes, rest homes, maternity homes, and homes for the aged, alcoholics, or drug addicts.

If the insured is confined for maternity care the company will pay benefits of up to $50 as a result of any one pregnancy. This benefit is in lieu of other policy benefits and is subject to a 10-month waiting period. New accidents are covered from policy issue, new sickness from 30 days after policy issue. ("Sickness means sickness or disease contracted and commencing after this policy has been in force not less than 30 days, after date of issue.")

The policy does not cover confinements due to alcoholism, mental disturbance, or for dental treatment. There is a 6-month waiting period before confinements for treatment of tuberculosis, heart disease, and other specified conditions are covered.

[6] If the insured has other insurance, then the deductible is the amount of the benefits payable under the other insurance or $500, whichever is greater. In this case the maximum benefit is increased by three times the amount by which the benefits payable under the other insurance exceed $500.

The policy is guaranteed renewable to age 65 at rates in effect on the respective renewal dates. Monthly premium rates for the $150 per week lifetime benefit are as follows:

Sex	Age at issue					
	0–17	18–29	30–39	40–49	50–59	60–64
Men	$1.80	$4.35	$5.10	$6.00	$7.20	$9.15
Women	1.80	7.20	8.55	9.60	10.50	11.40

A widely advertised policy of the same nature, offered to individuals aged 40 and over, pays $100 a week for 52 weeks. Coverage begins immediately for accidents, after 30 days for sickness. Mental disorders, alcoholism, and drug addiction are excluded. Pre-existing conditions are covered after 1 year. Preventive care is encouraged by payment of up to $10 toward the cost of an annual routine health examination. Premium rates, the same for men and women, are:

Aged 40–54	$3.95
Aged 55–64	5.95
Aged 65–74	7.95
Aged 75 and over	9.95

Overinsurance

The possession of two or more individual policies (or of group and individual policies) covering the same types of health care expense can result in an individual "making a profit on an illness," i.e., receiving aggregate benefits exceeding the expenses incurred. Such overinsurance can encourage prolongation of hospital stay and other types of excessive utilization, and is generally regarded as undesirable. (To put the matter in proper perspective, for every holder of multiple individual policies whose aggregate benefits during an illness exceed expenses, there are probably 10 times that many whose benefits fall short of meeting the expenses incurred.)

Insurance companies writing group policies have apparently developed workable procedures for coordination of benefits under group policies, so that persons covered under two group policies do not receive benefits in excess of expenses incurred. Companies writing individual policies have given attention to the problems of overinsurance but, thus far at any rate, have been less successful in developing workable procedures. Two approaches have been discussed within the industry and adopted to a limited extent by some companies, as noted in the illustrative policies cited. One involves the insertion in the policy of a provision to the effect that if the insured has other valid coverages, not with the particular insurer, providing benefits for the same loss, and of which the insurer has not previously been notified, and which result in the insured receiving aggregate benefits exceeding the expenses incurred, the issuing company's liability is reduced to its pro rata share of the total expenses incurred, and the company will return a corresponding proportion of the premium.

The second approach, applicable to major medical policies, involves insertion of a provision to the effect that if the insured has other coverages, the deductible under this major medical policy will be the larger of (a) the benefits payable under the other policy or (b) the specified deductible in this policy, and that the maximum benefit payable will be increased by three times the amount of the increase in the effective deductible because of this arrangement.

These and other approaches all seem to be more favorable to the insurance company than to the insured. Furthermore, their implementation depends upon the insurance company's being informed of the other coverages. To date the problem remains unsolved and continues to be the cause of much concern.

Summary

Benefits under insurance company individual policies are, in general, similar to those under group policies, except that there is relatively much less coverage of the major medical type and benefits are more limited. While the purchaser can, at a price, find a policy providing almost any coverage he wants, the great majority of policies provide rather limited benefits for hospital and surgical care only. Due to the relatively high expense of selling and administering individual

policies, potential benefits in relation to premiums are much less favorable than under group policies.

Because of the problem of adverse selection of risks, individual policies universally exclude preexisting conditions, frequently exclude mental illness, and frequently have waiting periods for various other conditions.

To an increasing degree individual policies are offered to supplement other coverages that a person may have. Possession of multiple coverages of the same expenses can lead to overinsurance, which may encourage excessive utilization of care.

Chapter 6

INDEPENDENT HEALTH INSURANCE PLANS

THE SO-CALLED independent health insurance plans comprise all plans or organizations providing health care or health care benefits on a prepayment or insurance basis other than Blue Cross and Blue Shield plans and insurance companies. There are six general types of plans: (a) community group practice plans; (b) community individual practice plans; (c) employer-employee-union plans, some of which provide care through group practice and others through individual practice; (d) private medical group clinic plans; (e) dental service corporation plans; and (f) private dental group clinic plans. All told, there are over 600 independent plans, some quite large in terms of number of people covered, most quite small.[1]

Although independent plans cover only 6 percent of the net number of persons enrolled by all private health insurance organizations, they nevertheless make up a significant segment of the health insurance industry. Many independent plans directly provide service through group practice arrangements that in the view of some hold promise for the future. Many have pioneered in the offering of new and broader health service benefits—for example, comprehensive physician service, dental care, vision care, and prescribed drugs.

This chapter deals with the specific benefit provision of selected representative independent plans. Included in the analysis are the nine largest community group practice plans, one very large community plan providing benefits through individual practice arrangements, two large employer-employee-union plans, the largest private medical group clinic plan, the largest dental service corporation, and one private dental group clinic plan. In general, where a plan has more than one subscriber contract, only the most widely held group contract is dealt with. The data on the plans dealt with were obtained directly from them. However, much helpful information on the dental service corporation plans was provided by the Division of Dental Health, Bureau of Health Professions Education and Manpower Training, the National Institutes of Health.

Community Group Practice Plans

All community group practice plans provide comprehensive physician service through group practice arrangements. Most plans have a single staff or group of physicians; one provides care through contract with more or less autonomous private medical groups. In some plans the physicians are paid on a salaried basis; in other plans the physicians are members or employees of physician partnerships,[2] which are remunerated on the basis of a negotiated rate per capita of the group served. Benefits are in the form of service. Within

[1] For detailed information on independent plans as of 1964, see Louis S. Reed, Arne H. Anderson, and Ruth S. Hanft, *Independent Health Insurance Plans in the United States—1965 Survey*, Research Report No. 17, Office of Research and Statistics, Social Security Administration (Washington: U.S. Government Printing Office, 1966). ORS in 1969 conducted another survey of all independent plans, the findings of which will be published in mid-1970.

[2] Some of these are legally organized as corporations.

the plan area, subscribers, except in special circumstances, receive care only from the plan's medical staff or medical groups. There are about 30 community group practice plans in the United States. The nine largest plans here dealt with probably have 90 or 95 percent of the total subscribers served.

DESCRIPTION OF PLANS AND SERVICE AREAS

The nine plans dealt with are: Community Health Association (Detroit, Mich.), Community Health Foundation (Cleveland, Ohio), Group Health Association, Inc. (Washington, D.C.), Group Health Cooperative of Puget Sound (Seattle, Wash.), Health Insurance Plan of Greater New York, and the Kaiser Foundation health plans of Northern California, Southern California, Oregon, and Hawaii. Each of these nine plans is organized on a nonprofit basis, serves the general community of the area, and, except for the Kaiser plans, is controlled by a board of directors composed of persons representative of the general community or the subscriber groups served.[3]

The Community Health Association (CHA) of Detroit, with some 79,000 participants, provides services through a hospital and five outlying clinics owned by an affiliated nonprofit group. Service is provided by a full-time salaried medical staff. CHA serves a five county area of Detroit.[4]

Community Health Foundation (CHF) of Cleveland contracts with a group of physicians organized as a partnership or association, who provide care in the plan's two health centers. The physicians have privileges in and use four area hospitals. The plan's 31,000 enrollees live in the Cleveland metropolitan area. Effective January 1, 1969, this plan became a part of the Kaiser Foundation Health Plan, Inc.

Group Health Association, Inc., with approximately 69,000 enrollees, serves persons in the Washington, D.C., metropolitan area through its own salaried medical staff housed in two clinics. The plan does not have its own hospital and uses several hospitals in which its physicians have privileges. The majority of those served are Federal employees and annuitants and their dependents who have selected this plan under the Federal Employees Health Benefits program.

Group Health Cooperative of Puget Sound has 101,000 members. Its salaried medical staff provides service in the plan's hospital and central medical clinic and three ancillary clinics.

The Health Insurance Plan of Greater New York (HIP) provides physician service through 31 contracting medical groups. These groups in all but a few cases are organized as physician partnerships; each group is paid a set amount monthly for every participant who has elected to receive care from the group. HIP serves approximately 756,000 persons in the greater New York area.

The four Kaiser Foundation health plans together have more than 1.6 million participants. Each plan is autonomous to a large degree. Each has its own hospital or hospitals (more than 12 in all) and various ancillary clinics. The physicians of each plan are independently organized as a partnership or incorporated association and provide service to the plan at a negotiated rate per participant. The Kaiser Plan of Northern California serves largely the bay area and Sacramento. The plan in Southern California serves the Los Angeles and San Diego areas. The plan in Oregon serves the Portland metropolitan area. The plan in Hawaii serves Honolulu and the Island of Oahu.

Tables 6–1 through 6–5 show the subscription costs, benefits, exclusions, and limitations under the contracts or membership agreements that are most widely held by group enrollees. The provisions described pertain to non-Medicare enrollees.

SUBSCRIPTION CHARGES

Data on monthly subscription charges[5] were available for eight of the nine plans. The Community Health Association (Detroit) did not report a rate, explaining that charges are different for each membership group and that in some cases their rates are composite rates that include coverage of the full benefits for persons under age 65 and the complementary-to-Medicare benefits for members aged 65 and over.

[3] The four Kaiser plans, each largely autonomous, are controlled in the last analysis by a board of directors consisting of Kaiser company executives. There is no formal representation on the Board of the persons served.

[4] The enrollment figures given here are all as of the end of 1967.

[5] Data on subscription charges and benefits are all as of early 1968.

Excluding HIP, which does not cover hospitalization for the great majority of its subscribers, the monthly subscription costs for one person range from $9.85 for the Kaiser plan of Oregon to $16.66 for GHA. Family premiums ranged from $28.10 to $42.42 for these same two plans, respectively. Obviously, this wide range in subscription costs not only reflects significant variations in the type and extent of benefits provided, but also differences in levels of physician remuneration and hospital costs.

SERVICES COVERED IN WHOLE OR IN PART

Table 6-1 outlines the major services covered in whole or in part by the plans; subsequent tables provide data on extent of or limitations of benefits for each service covered, direct charges levied for particular items of service, conditions covered or excluded, etc.

All plans except HIP cover hospitalization (HIP subscribers have hospitalization benefits through Blue Cross or an insurance company). Two plans provide some coverage of care in nursing homes and/or extended care facilities. All plans provide comprehensive physician service, i.e., all needed service in the office (clinic), home, and hospital, including X-ray and laboratory examinations, periodic health examinations, and immunizations. However, most have charges for the initial home call in an illness, or for night home calls, or all home calls, and some require a small payment for office visits or for various special services.

Six plans cover special or private duty nursing in the hospital, but none covers this service in the home. Six plans also cover the services of visiting nurses.

None of the plans covers dental care under its regular program,[6] although two have affiliated dental prepayment plans that members may join.[7] In both cases only a small proportion of the total membership participates in the separate dental plan. Only two plans cover out-of-hospital prescribed drugs on a prepayment basis under their most widely held contract. One of these provides all necessary drugs at no extra cost; the other pays 80 percent of the cost of prescribed drugs in excess of $50 a year for each member. However, all except two of the plans have their own pharmacies, at which (excepting the one plan that provides all prescribed drugs under its prepayment program) drugs are sold to members usually at prices slightly below those of commercial pharmacies. Several of the plans that do not cover drugs under their most widely held contract offer other contracts under which drugs are covered in full or provided at a small charge per prescription.

As regards vision care, all plans provide eye refraction examinations. None provides eyeglasses on a prepayment basis. However, all or almost all the plans have optical units that furnish eyeglasses at prices somewhat lower than those charged on the outside.

None of the plans provides appliances (artificial limbs, braces, crutches, etc.) under its prepayment programs and none furnishes them on a charge basis. All plans but one (CHA) cover the cost of ambulance service when prescribed by a plan physician or in an emergency.

HOSPITAL BENEFITS

Table 6–2 gives details of the hospital benefits offered by the plans for care of general illness, mental illness, and tuberculosis.

Each of the eight plans that covers hospitalization provides care in semiprivate accommodations. The plans with their own hospitals generally provide care in a private room at no extra cost when this is medically necessary; otherwise there is an extra charge. GHA stipulates that if for any reason a private room is used, the member must pay the difference between the charge for it and the hospital's usual semiprivate room charge. Hospital care includes all of the special hospital services.

The plans provide care for varying periods. CHA and CHF provide 365 days of hospitalization per admission, with any re-admission within 90 days of discharge viewed as a continuation of the former period of care. GHA places no limit on the days of hospital care that will be provided.

[6] However, virtually all provide such dental care as is required because of an accidental injury.

[7] GHA and Group Health Cooperative. GHA's dental prepayment plan mainly serves children; however, the plan's dental clinic provides much service to adults and children on a fee-for-service basis.

Group Health Cooperative covers 180 days per admission. The Kaiser plans of Northern California and Oregon provide 111 and 180 days per condition each calendar year, respectively. The Kaiser plan of Southern California covers 125 days per calendar year with an additional 240 days covered at one-half the prevailing rate. In Hawaii, the Kaiser plan covers 150 days per condition each calendar year, with an additional 215 days provided at one-half the prevailing rate.

Benefits for mental illness and tuberculosis are less extensive. Of the eight plans covering hospital care only four cover mental illness in a general hospital and only one covers mental illness in a mental hospital, private or public. CHA and CHF cover 45 and 30 days of care in a general hospital, respectively. CHA also covers 90 days of care for mental disorders in a night care center. GHA limits hospital coverage of mental illness to care in a general hospital during the acute phase of illnesses that in the judgment of GHA doctors are subject to improvement through short-term therapy. The Kaiser Oregon plan covers care in both general and specialized hospitals at the rate of 50 percent of the value or charge for such care, including charges for professional service, up to a maximum of $500.

Care of tuberculosis in general hospitals is covered by only three plans. CHA and CHF limit such care to 30 days per admission, whereas GHA has no limit on the number of days covered. No plan covers treatment of tuberculosis in TB hospitals.

NURSING HOME AND ECF CARE

CHA covers care in a skilled nursing home for 730 days per confinement. Any re-admission within 90 days of discharge is considered a continuation of the prior confinement. The 730-day period will be reduced by 2 days for every day spent in the hospital. Conversely, the hospital benefits will be reduced by 1 for every 2 days of nursing-home care. This benefit does not apply to custodial or domiciliary care for members primarily in need of protection or simple health maintenance services. The Kaiser plan of Oregon has a long stay hospital unit that, in effect, functions as an extended care facility. A day of care in this unit is counted as a day of hospital care.

PHYSICIAN SERVICES

All of these plans provide comprehensive physician services without limits as to frequency, duration, or value. They undertake the responsibility of providing whatever service is deemed necessary for health care, including such preventive services as periodic health examinations, well-baby care, and immunizations.

However, most of the plans make minor charges for one type of service or another, as shown in table 6–3.

Three plans under their most widely held contracts make a small charge—$1 by two plans and $2 by one plan—for each clinic visit. All of these plans offer other contracts under which there is no such charge.

Almost all of the plans make a charge either for all home calls or for calls at night or for the first call or first two calls in an illness. The general rationale, of course, is to deter subscribers from asking for a home call unnecessarily, especially at night. Three plans make a charge for all home calls. One plan makes a charge only for night calls, i.e., those occurring after 10 p.m. Four plans make a charge for the initial call or the first two calls in an illness.

None of the plans makes any special charge for in-hospital visits. One plan charges $1 for each X-ray or laboratory examination. The same plan charges for each visit to the physical therapy department. Another plan makes a charge for the first two such visits. A majority of the plans charge for the materials used in immunizations and injections; usually such charges are quite small.

NURSING SERVICES

As already noted, six plans cover special or private duty nursing in the hospital. Four of these are the Kaiser plans. They have their own hospitals. If a patient needs special nursing care and is not in an intensive care unit, such extra or special nursing service as he needs will be provided. This is done by the hospital's regular staff and not by engagement of a private duty nurse. The same provision holds in the Group Health Cooperative plan. GHA, which does not have its own hospital, will pay for private duty nursing for a critically ill patient when this is deemed necessary by the Medical Program Administrator.

All but three of the plans provide visiting nurse service. This is generally arranged through the local visiting nurse association, i.e., the plan pays the charges for nurse visits when these are ordered by the patient's doctor.

BENEFITS FOR MATERNITY AND OTHER SPECIFIED CONDITIONS

As seen in table 6–4, four of the plans under their most widely held contract have no waiting period before maternity benefits for normal delivery are made available. Four of the plans have a waiting period of 10 months and one has a waiting period of 9 months. (These plans will waive the waiting period under special arrangements with large enrollee groups.) Supplementary charges for maternity benefits are made by four plans. GHA requires that the subscriber pay the first $50 of charges for hospital service in maternity cases. Group Health Cooperative charges $150 for maternity care. The Kaiser plans of Northern and Southern California charge $60 and $100, respectively, for maternity care with higher charges if the 10-month waiting period is not met. In some plans there is also a charge for care of interrupted pregnancies (miscarriage) if there is hospitalization.

There are restrictions on or exclusions of service for certain other conditions. Six plans exclude out-of-hospital psychiatric care for mental illness after diagnosis. Of the three that cover this type of care, one plan (GHA) pays for up to $15 each for up to 16 consultations a year, if the condition is one that is subject to improvement through short-term treatment. Another limits plan benefits to a maximum of $500 a year (including hospital services), the patient to pay half of the cost of all services. The third covers without qualification.

Physician service in the office for tuberculosis is covered by five plans and under the terms of the most widely held contract seems to be excluded by four plans.

Six plans exclude care for alcoholism and drug addiction; the other four presumably cover care for these conditions. No plan covers cosmetic surgery for beautification purposes, but all cover cosmetic surgery when necessary to correct the results of disease or injury incurred while the person was a plan member or to correct congenital anomalies in children born to plan members.

Under their most widely held contracts, all plans but one cover pre-existing conditions. The exception is Group Health Cooperative, which excludes from coverage conditions under active treatment 60 days prior to date of coverage and conditions causing invalidity prior to date of coverage. All plans but one cover sterilization—at least the contracts make no mention of exclusion. The exception, again Group Health Cooperative, excludes sterilization unless performed for therapeutic reasons.

Congenital conditions are unconditionally covered by six plans and covered only to some extent or under certain circumstances by three plans. Intentionally self-inflicted injuries are excluded from coverage by two of the plans.

CARE OUTSIDE THE PLAN AREA

Table 6–5 outlines the benefits available to plan members when they must receive care outside the plan's service area. In most instances, this care is restricted to treatment of emergency illness or accidental injury.[8] Such benefits are, in general, less comprehensive than the plan's regular in-service area benefits and are often in the form of indemnity allowances against charges incurred. The most common type of restriction is on the aggregate dollar value of services for which the plan is liable in each case. HIP, for example pays a maximum of $350 for each case for emergency physican services. Kaiser of Hawaii makes a maximum payment of $2,000 for emergency hospital and medical services. Other restrictions are found in the form of a deductible feature (GHA).

Most of the group practice plans have entered into reciprocal arrangements with other plans, through the Group Health Association of America, whereby members can obtain care from other plans when in their area. Among the Kaiser plans, subscribers are eligible to receive service benefits in the facilities of each of the other Kaiser plans. The value of such reciprocal arrangements to the member traveling outside his plan area is, of course, quite limited since there are so few group practice plans.

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[8] Care for specialized services outside the plan area that is arranged for by the plan is covered.

Community Individual Practice Plans

There are only a few independent plans serving the general community that provide benefits on what may be termed an individual practice basis (free choice of physician, fee-for-service), and most of them are quite small. By all odds the largest and most important is Group Health Insurance, Inc., which serves the New York metropolitan area and has over 1 million subscribers.

GROUP HEALTH INSURANCE, INC.

This plan offers two major types of contracts, one covering surgery, obstetrical care, and in-hospital physician visits, the other covering comprehensive physician service. The latter contract will be dealt with here. The plan does not cover hospitalization except for a small minority of subscribers.

The so-called "Family Doctor Plan" covers all physician care, specifically surgery and obstetrical care including anesthesia service, in-hospital physician visits, in-hospital consultations by a qualified specialist, family doctor office and home visits, out-of-hospital consultations by a qualified specialist on referral by the family doctor, out-of-hospital X-ray and laboratory examinations, and shock therapy. Preventive care, including periodic physical examinations, well-baby care, and immunizations, are covered. Visiting nurse service and ambulance service are also covered.

Members have free choice of physician. Over 11,000 physicians in the New York metropolitan area have become "participating physicians," and agree to accept payment directly from the plan and to accept the plan's scheduled payments as full payment for their services, i.e., no extra charge to the subscriber is permitted. However, if the patient takes a private hospital room, then the physician may make an extra charge. Also specified extra charges may be made for evening and night home calls. If a member uses a nonparticipating physician, the scheduled allowances are paid to the member.

In general, there are no limits on number of necessary services or visits that will be paid for, and no overall maximum on value of services. In-hospital psychiatric care and care for tuberculosis is covered for no more than 30 days in each calendar year. Shock therapy is limited to 10 treatments. Psychiatric care outside of the hospital (except for an initial consultation) is not covered under the most widely written contract, although it is covered under some contracts.

Eye examinations for eyeglasses are not covered. Cosmetic surgery, unless required because of an accident or illness during the period of membership, is excluded. There is a waiting period of 6 months for removal of tonsils and adenoids and of 9 months for the treatment of preexisting conditions. Both may be waived for large enrolled groups.

Premiums for the contract here described for non-experience-rated groups are $5 monthly for an individual and $18 for a family. The plan experience-rates all large groups, and rates for these groups would be higher or lower depending upon experience.

Group Health Insurance, Inc., has an affiliate, Group Health Dental Insurance, Inc., which provides dental care benefits. At the end of 1968 it served 280,000 persons. Covered persons have free choice of dentist and the plan has over 5,000 participating dentists who agree to accept the plan's scheduled fees or allowances as full payment for their services.

The plan writes a number of contracts along two basic approaches, one with a deductible and coinsurance, the other without a deductible, and with coinsurance as regards only certain services. Contracts of the first type have a family annual deductible of $25, $50, $75, or $100 and pay 80 percent of the scheduled allowances. Illustrative scheduled allowances are: examination, $5; cleaning (persons over 12 years of age), $7; X-rays (full mouth), $15; one surface amalgam filling, $5; full cast gold crown, $56; extractions by general practitioner, $6.45; by specialist, $10.40; full upper or lower denture, $150. The charge for this contract with a $25 deductible is $2.18 a month for an individual, $6.50 for husband and wife, $14.35 for a family (without orthodontia benefits), and $17.40 (with orthodontia benefits). Rates for the $100 deductible contract are about half of those cited above.

The comprehensive plan provides the same allowances, but without deductible or coinsurance, except for prosthetics (dentures, bridgework, and crowns). The charge for this plan, without pros-

thetic services, is $2.28 for an individual, $5.47 for husband and wife, $13.10 for a family (without orthodontia benefits) and $17.10 (with orthodontia benefits). For the most comprehensive contract in the series, one paying 100 percent for prosthetics, the charge is $4.55 a month for an individual, $10.85 for a husband and wife, $18.90 for a family (without orthodontia) and $22.90 (with orthodontia).

The above rates apply during the first 15 months; subsequent premiums are based on the group's experience.

Employer-Employee-Union Plans

Employer-employee-union plans are operated by jointly managed welfare funds, employers, employee benefit associations or unions and serve a specific group of employees or union members and usually their dependents. A minority provide care through group practice arrangements; the majority use individual practice arrangements and generally provide scheduled allowances against charges incurred. Many of the group practice plans operate labor health centers with care restricted to physician service at the center.

Many plans, in addition to directly providing one or more types of health benefits, also purchase coverage of other health benefits from a Blue plan, insurance company, or a community independent plan. In general, the pattern of benefits in employer-employee-union plans is different from that of the community plans in that relatively fewer persons are covered for hospital care, surgery, or in-hospital visits and relatively more are covered for physician office care, dental care, drugs, appliances, and nursing-home care.[9]

The specific benefit provisions of two of the larger employer-employee-union plans are examined herein—those of the United Mine Workers of America Welfare and Retirement Fund and the National Association of Letter Carriers. (The last plan is a carrier under the Federal Employees Health Benefits program.) Both plans provide considerably more comprehensive benefits than most employer-employee-union plans.

UNITED MINE WORKERS OF AMERICA WELFARE AND RETIREMENT FUND

The fund provides hospital-medical services and pension and survivor benefits from revenues derived from royalty payments of 40 cents on each ton of coal produced for use or for sale by mine operators signatory to a coal trust agreement with the union. Headquartered in the District of Columbia, the fund serves nearly 500,000 beneficiaries and makes payments each year to nearly 1,200 hospitals and 8,000 physicians in all 50 States and the District of Columbia. Hospitals and physicians are paid fully and directly by the trust fund, which pays the entire cost of all benefits provided. No contributions or payments of any sort by miners are made to the fund.

The fund's administrative structure includes 10 area medical offices located throughout the bituminous coal mining areas. Arrangements for delivery of services are made with physicians, hospitals, and clinics, which agree to provide services in accordance with the fund's medical, health, and hospital service agreement. A central feature of the fund's program involves the services of managing physicians who become responsible for personally supervising the entire range of care received by the beneficiary. The fund has developed a fee-for-time or retainer method of payment, which is used for paying about 70 percent of the participating physicians. The method of reimbursement is based on the amount of the physician's time devoted to beneficiaries and includes an equivalent percentage payment of the physician's overhead costs. The fund also has been instrumental in stimulating the development and expansion of 37 group practice clinics in coal mining communities from which the fund purchases services the same as from other physicians or groups.

Through these arrangements, the fund provides all necessary hospital care in semiprivate accommodations for as long as medically required. There are no financial or numerical restrictions on any hospital services, including X-ray and laboratory services, drugs, special duty nursing, anesthesia, use of operating and delivery room, and all supplies and equipment. Likewise, unlimited medical,

[9] See Louis S. Reed, et al., *op.cit.*

surgical, and follow-up care are covered, including outpatient care, specialist office and clinic visits, and consultations. Other benefits include extensive physical rehabilitation, certain costly out-of-hospital prescribed drugs (when necessary for treatment of long-term illness), appliances, nursing-home care in approved facilities, and ambulance service as medically necessary. The fund also provides glasses when required following eye surgery. It covers treatment of short-term psychiatric care. Dental care is covered only when essential for the treatment of certain medical conditions. Payment is also made to physicians whom the beneficiary may select for emergency or other services while he is living or traveling outside of coal mining areas.

There are no restrictions or waiting periods for the receipt of any services, including maternity benefits. The fund has no specific exclusion of any disease or condition. However, it does not cover diseases or conditions, e.g., mental illness or tuberculosis, when care for them can be obtained through tax supported or voluntary agencies.

Eligible beneficiaries include miners (while employed or if unemployed for 12 months after employment ceases), pensioners, wives, dependent parents, and dependent children up to age 22. Widows and their dependent children are eligible for medical care benefits for 5 years after the death of the miner and 2 years after the death of a pensioner.

The fund spent $47,300,000 for its medical program (including administrative expenses) in 1967, equal to approximately $100 per eligible beneficiary.

NATIONAL ASSOCIATION OF LETTER CARRIERS PLAN

This employee organization plan provides benefits under the Federal Employees Health Benefits program. The plan has headquarters in Washington, D.C., and serves more than 500,000 enrollees through its indemnity benefit plan. Payment for services provided may be made directly by the plan to hospitals and doctors (except where benefits involve deductibles). Benefits under the plan's high option provisions are described below. Monthly subscription costs (including the Government's contribution) in 1968 for this option were as follows: for a single enrollment, $8.58; for family enrollment, $26.17.

The plan pays, for up to 365 days per confinement, the first $3,000 of hospital room and board charges (for semiprivate accommodations) plus 80 percent of any such charges over these amounts and the first $1,000 of charges for other hospital services plus 80 percent of additional charges. These other hospital benefits include all medically required hospital services, supplies, and medicines, and, whether or not directly provided by the hospital, X-ray and laboratory examinations, the supply and administration of anesthetics and oxygen, blood and blood plasma, and local ambulance service.

Charges for necessary surgical procedures (in or outside the hospital) are covered up to amounts specified in the plan's schedule of allowances. If charges exceed the maximum scheduled allowance of $400 the patient must pay the next $200 after which the plan pays 80 percent of any remaining reasonable and customary charges.

The plan pays 80 percent of other covered medical expenses, after a deductible of $50 for each person each calendar year, up to a maximum of $15,000 per calendar year. These other medical benefits include doctors' office, home, and hospital visits, private duty nursing in the hospital and home, out-of-hospital prescribed drugs, out-of-hospital diagnostic X-ray and laboratory examinations, and X-ray and radium therapy, anesthetics and oxygen, ambulance service, and appliances.

For nonsurgical treatment of accidental injury, patients treated as other than hospital inpatients are allowed up to $50 when no other benefit is payable by the plan.

Hospital benefits for mental illness or tuberculosis are limited to 30 days in a 12-month period. Other covered charges are paid up to $400 on the same basis as for other illness, and then at 50 percent to a combined total of $3,000. Regular hospital benefits apply in maternity cases. For a normal delivery the maximum allowance for doctor's services is $100. The plan does not cover care in nursing homes or custodial care facilities. It excludes eyeglasses, hearing aids and examinations for these, routine physical examinations, and immunizations. Cosmetic surgery is covered only when necessary for repair of accidental injury (within 6 months of accident), or to correct congenital anomalies of a child born to a member.

Private Medical Group Clinic Plans

Some 20 or 30 private medical group clinics serve patients on a prepayment basis, though frequently the number of patients served on a prepaid basis is small in comparison with those served on a fee basis. By far the largest private group clinic plan is that of the Ross-Loos Medical Group in Los Angeles, California. This group provides almost all of its service on a prepaid basis and makes available relatively comprehensive physician service to its subscribers.

Under one large group contract (Los Angeles Department of Water and Power Employees Association) beneficiaries are entitled to an allowance of $35 a day for 120 days for hospital room and board expenses. All other necessary hospital services, including anesthesia, are covered up to $300 plus 75 percent of the next $5,000 for any one sickness or injury. Outpatient services for emergency treatment of an injury within 24 hours of an accident are covered. Ambulance transportation to or from a hospital is covered up to $50. Charges of private duty nurses in accident cases are covered on a 50-percent coinsurance basis up to a maximum benefit of $200. These benefits are underwritten by an insurance company.

The medical group provides surgical service, physician visits in the hospital, office, and home, X-ray and laboratory examinations, periodic health examinations and eye refractions—all at no cost to the member, but at small service fees to dependents. Examples of the latter are fees of $25 for major operations, $1.25 for office calls or consultation, $5 for home calls, and $1.25 for eye refractions, and scheduled fees for X-ray and laboratory examinations. Complete obstetrical care is provided to a member or a dependent wife, but the member pays the first $125 of hospital charges and the plan pays the balance, but not more than $25 a day for the mother's room and board.

Hospital care for mental illness is covered in general hospitals but not in mental hospitals. The same holds for tuberculosis. Psychiatric care outside the hospital is provided at Ross-Loos offices at about one-half the charges made for nonmember patients. Outside the service area, the plan provides its regular hospital benefits and covers medical expenses incurred up to $500 for each injury or for all illnesses.

The monthly cost of the plan for an employee only is $11.50; for an employee and one dependent, $25.55; and for an employee and two or more dependents, $29.30.

Dental Service Corporation Plans Sponsored by Dental Societies

Dental service corporation plans sponsored by dental societies are growing in number and enrollment. Fourteen plans were in operation at the end of 1967 with a total enrollment of 1.3 million persons. These plans are similar to Blue Shield plans; they are nonprofit, provide benefits on a free-choice-of-dentist basis and are controlled by boards of trustees composed wholly or mainly of dentists.

The 14 dental service corporations provided coverage to 243 enrolled groups at the end of 1967. The coverages provided to some of these groups are summarized in the *Directory of Prepaid Dental Care Plans, 1967*, issued by the Division of Dental Health of the Bureau of Health Professions Education and Manpower Training of the National Institutes of Health. Plans included in the directory are classified as providing minimum, basic, intermediate, or comprehensive coverage. Minimum plans offer at least three benefits—emergency treatment for relief of pain, dental examination, and radiographs. Basic plans include all three minimum benefits plus prophylaxis, routine fillings, single extractions, and topical fluoride applications. If the plan contains only one or two of the basic services, it is listed as minimum plus those one or two additional benefits. To be classified as an intermediate plan all basic services must be included plus space maintainers, inlays, crowns, oral surgery, and full and partial dentures. Again, if all additional services were not covered, the plan was designated as a basic plan plus additional services. Comprehensive plans include all intermediate

dental services, plus periodontal treatments, fixed bridges, root canal therapy, and orthodontic care. If all services were not covered the plan was designated in the lesser category plus the additional service.

Of the coverages provided to the 243 groups, 84 percent were classified as intermediate plans but less than comprehensive, 10 percent were comprehensive, and the remainder were basic or variations of basic and intermediate.

Contract provisions under the dental service corporations generally include deductible and/or coinsurance features and a limitation on the maximum benefits receivable in a specified time period. Of the 243 coverages, 58 percent figure benefits on the basis of a schedule of allowances, 33 percent on the basis of usual and customary fees, and the remainder on other bases, including information not available.

CALIFORNIA DENTAL SERVICE CORPORATION

The California Dental Service Corporation is by far the largest in the country, serving almost 900,000 persons at the end of 1967. Most of its contracts cover all dental services other than orthodontia. Some typical contracts in effect early in 1969 had the following provisions and rates:

One contract covered diagnostic services, including X-rays; prophylaxis once every 6 months; oral surgery (extractions); restorative dentistry (fillings, etc.); endodontics; periodontic treatments; and after enrollment for 12 months, prosthetics (bridges and dentures, the latter limited to once every 5 years). Services not covered were congenital malformations, orthodontic services, and services purely cosmetic in nature. The plan paid 80 percent of the amounts listed in a table of allowances, but not more than the dentist's usual, customary, and reasonable fee, subject to a deductible of $35 for each patient per year, with an annual maximum limit on benefits per person of $600. Illustrative allowances are: prophylaxis for child, $6, and for adult, $9; complete X-ray examination, $17; uncomplicated extraction, $8; amalgam one-surface filling, $8; three-fourths gold crown, $60; complete upper or lower denture, $155. Rates for groups of 50 to 100 employees (rates for smaller groups are higher) were $5.40 a month for one person; $8.80, for two persons; and $12.90, for three or more persons.

Another contract covers the same services. During the first year, it pays 70 percent of the dentist's usual, customary, and reasonable fees (all participating dentists annually file their usual, customary, and reasonable fees with CDS and these are reviewed as to reasonableness), provided the dentist is affiliated with CDS. If the dentist is not affiliated, the plan pays the same percentage of amounts in its table of allowances (see above for illustrative allowances). During the second year, the percentage paid increases to 80 percent, providing the patient visited his dentist at least once in the preceding year and had all prescribed treatment rendered. In the third year, on the same conditions, the proportion increases to 90 percent and in the fourth year, on the same conditions, to 100 percent. The percentage of payment for prosthetics, however, is always 50 percent. The maximum benefit per person per year is $750. The monthly rate for one person is $6.12; for two persons, $10.58; and for three or more persons, $15.22.

Another contract covers all the above services and orthodontia. The plan pays 100 percent of the dentist's usual, customary, and reasonable fees for basic services, and 50 percent for prosthetic services, but not more than the same percentages of amounts in the plan's table of allowances. The maximum benefit per person per year is $750. The plan pays 50 percent of the total cost of approved orthodontic care not to exceed $500 as a lifetime benefit for any individual. Rate: $14.16 per employee in a covered group, with or without dependents.

Private Dental Group Clinic Plans

A number of private dental groups offer service to patients on a prepaid basis. As in the case of private medical group clinic plans, most of these serve patients both on a fee and prepaid basis.

An illustration of such a plan is a group clinic in Los Angeles, California, which has a staff of 13 full-time dentists and three dental hygienists. The group serves over 6,000 persons in various em-

ployee groups on a prepaid basis. A little more than half of the group's practice is on a fee-for-service basis.

Under a typical group contract, the group covers virtually complete dental care, other than orthodontics and space maintainers, but with the patient paying laboratory costs for prosthetics and fixed bridge benefits. Benefits for children are provided under a schedule of charges but without additional laboratory charges. The contract in the first year covers only the employee; spouse and dependent children are covered after 1 year. The cost of this coverage in 1968 was $7.50 per month per employee during the first year of coverage, which was scheduled to increase to $8.30 per month per employee (with or without dependents) for employees covered more than 1 year.

Summary

Community group practice prepayment plans differ from the Blue Cross and Blue Shield plans and those of insurance companies in that they directly provide service to their subscribers and do not merely pay the charges of independent physicians and hospitals. Since they directly provide service, these plans are concerned at every turn with the quality of care provided; their basic aim is to provide high quality care at reasonable cost.

The community group practice plans pride themselves on providing "comprehensive" health service. All of them do provide complete coverage of physician service and those that cover hospital care provide a coverage that is complete or nearly so, although in some cases the coverage of mental illness or tuberculosis is less inclusive than that provided by many Blue Cross or Blue Shield plans or insurance companies. However, none of the plans provides a fully comprehensive health service if by this one means hospital care, physician service, dental care, nursing service, drugs, and all other necessary health services and supplies. The term "comprehensive" in health insurance must be used with care.

The community individual practice plan described here indicates that at least one health insurance organization has found it possible to provide a virtually complete coverage of physician service on a free-choice fee-for-service basis to a large number of subscribers, and to do it economically. The dental service corporation plans and the private dental group clinic plans illustrate approaches in the provision of dental care on a prepayment basis.

TABLE 6–1.—Community group practice plans: Enrollment, subscription costs, and services covered in whole or in part

Plan	Enrollment as of Dec. 31, 1967	Monthly subscription costs (as of early 1968)			Services covered											
								Nursing service					Vision care			
		1 person	2 persons	Family	Hospital care	Nursing home or ECF care	Comprehensive physician service	Special or private duty nursing		Visiting nurse service	Dental care	Prescribed drugs (outside hospital)	Eye refraction examinations	Eye glasses	Appliances	Ambulance
								In hospital	In home							
Community Health Association (Detroit)	79,000	NA	NA	NA	C	C	C	NC	NC	C	NC	NC	C	PC	NC	NC
Community Health Foundation (Cleveland)	31,000	$14.40	----	$29.05	C	NC	C	NC	NC	C	NC	PC	C	NC [1]	NC	C
Group Health Association, Inc. (D.C.)	69,000	16.66	----	42.42	C	NC	C	C	NC	C	NC	PC–C	C	PC	NC	C
Group Health Cooperative (Seattle)	101,000	11.25	$22.50	[2] 35.45	C	NC	C	C	NC	NC	NC	C	C	PC	NC	C
Health Insurance Plan of Greater New York	756,000	[3] 4.50	9.00	[3] 13.50	NC	NC	C	NC	NC	C	NC	NC	C	NC	NC	C
Kaiser Plan (Northern California)	803,000	10.45	20.90	[4] 29.95	C	NC	C	C	NC	C	NC	PC	C	PC	NC	C
Kaiser Plan (Southern California)	695,000	11.30	22.60	[4] 32.00	C	NC	C	C	NC	C	NC	PC	C	PC	NC	C
Kaiser Plan (Oregon)	103,000	9.85	19.70	[4] 28.10	C	C	C	C	NC	NC	NC	PC	C	PC	NC	C
Kaiser Plan (Hawaii)	67,000	10.60	23.75	[5] 35.80	C	NC	C	C	NC	NC	NC	PC	C	PC	NC	C

NA Data not available.
C Service covered.
NC Service not covered.
PC Provided on charge basis.
[1] Plan will attempt to make arrangements whereby such aids may be obtained at reasonable rates.
[2] Family rate varies with number of children. This is rate for family with 3 or more dependent children.
[3] Basic certificate rates.
[4] Rate for subscriber and 2 or more dependents.
[5] Rate for subscriber and 3 or more dependents.

TABLE 6–2.—Community group practice plans: Inpatient hospital care for general illness, mental illness, and tuberculosis

Plan	General illness			Mental illness, days of care in—		Tuberculosis,[1] days of care in—	
	Accommodations	Days and basis	Coverage of hospital services	General hospital	Mental hospital	General hospital	Tuberculosis hospital
Community Health Association (Detroit)	SP	365 per admission [2]	Full	[3] 45 days	C [4]	[5] 30 days	NC
Community Health Foundation (Cleveland)	SP	365 per admission [2]	Full	[5] 30 days	NC	[5] 30 days	NC
Group Health Association, Inc. (D.C.)	SP	No limit	Full	C [6]	NC	C [7]	NC
Group Health Cooperative (Seattle)	SP	180 per admission	Full	NC	NC	NC	NC
Health Insurance Plan of Greater New York (New York)							
Kaiser Plan (Northern California)	SP	111 per condition [8]	Full	NC	NC	NC	NC
Kaiser Plan (Southern California)	SP	125 per cal. yr. [9]	Full	NC	NC	NC	NC
Kaiser Plan (Oregon)	SP	180 per condition [8]	Full	C [10]	C [10]	NC	NC
Kaiser Plan (Hawaii)	SP	150 per condition [11]	Full [11]	NC	NC	NC	NC

SP Semiprivate accommodations.
C Services are covered.
NC Services are not covered.
Cal.yr. Calendar year.
[1] After diagnosis as such.
[2] 90 days must separate admissions before renewal of benefits.
[3] Per admission with admissions separated by 90 days. This benefit is not intended to be the first 45 days of a chronic long-term commitment for conditions which in the professional judgement of the attending physician will not be responsive to therapeutic management. Plan also provides up to 90 days in a night care center for care of mental disorders. This 90-day period will be reduced by 2 days for every day spent in a hospital for mental illness. Conversely, the hospital benefit period for mental illness will be reduced by 1 day for every 2 days of care in a night care center.
[4] Covered in a hospital with which plan has an agreement.
[5] Per admission, with admissions separated by 90 days.
[6] Hospitalization benefits are the same as for general illness during the acute phase of mental illnesses which in the professional judgement of GHA doctors are subject to significant improvement through short-term therapy.
[7] Hospitalization benefits are the same as for general illness.
[8] In each calendar year.
[9] 240 additional days per calendar year are covered at one-half the prevailing rate.
[10] If care is received at a plan hospital, the member will pay 50 percent of the value of such care until the plan has provided a maximum of $500 of services (including professional services). If care is received at another institution or facility, the member will be reimbursed by the plan up to a maximum of $500 at the rate of 50 percent of the cost of such care. Psychiatric care will not be provided at facilities operated by governmental agencies.
[11] Each calendar year. An additional 215 days of care are provided at one-half the prevailing rate for room and board, general nursing, use of operating room, drugs and medications, injections, and special duty nursing. Full rates for other covered services.

Table 6–3.—Community group practice plans: Charges for physicians' services

Plan	Office visits	Home visits	In-hospital visits	Diagnostic X-ray and laboratory	X-ray therapy	Physical therapy	Immunizations	Injections
Community Health Association (Detroit)	$2 per visit	$4 first call during day. $6 first call at night.	None	$1	$1	$1	[1] $1	[1] $1
Community Health Foundation (Cleveland).	None	$5 first 2 calls	None	None	None	None	(1)	(1)
Group Health Association, Inc. (D.C.)	None	$5 first call	None	None	None	None	(1)	(1)
Group Health Cooperative (Seattle)	None	None	None	None	None	None	None	None
Health Insurance Plan (New York)	None	$2 from 10 p.m. to 7 a.m.	None	None	None	None	None	None
Kaiser Plan (Northern California)	$1 per visit	$3.50 for first 2 calls before 5 p.m. $5 after 5 p.m.[2]	None	None	None	None	(1)	(1)
Kaiser Plan (Southern California)	None	$5 per visit [2]	None	None	None	None	(1)	(1)
Kaiser Plan (Oregon)	$1 per visit	$2 per visit [2]	None	None	None	[3] $1	(1)	(1)
Kaiser Plan (Hawaii)	None	$5 per visit	None	None	None	None	(1)	(1)

[1] Charge for the materials.
[2] An additional charge of $2 will be made for each additional member who requires attention at the same household.
[3] No charge after the second visit.

Table 6–4.—Community group practice plans: Maternity benefits and coverage or exclusion of selected conditions

Plan	Maternity (normal delivery)		Psychiatric care of mental illness (out-of-hospital)	Tuberculosis (out-of-hospital)	Alcoholism	Drug addiction	Cosmetic surgery	Pre-existing conditions	Sterilization	Congenital conditions	Self-inflicted injuries
	Waiting period (months)	Charge									
Community Health Association (Detroit)	None	None	C	C	C	C	NC	C	C	C	C
Community Health Foundation (Cleveland)	9	None	NC	C	NC	NC	NC	C	C	C	C
Group Health Association, Inc. (D.C.)	None	[1] $50	C [2]	C	C	C	NC	C	C	C [3]	C
Group Health Cooperative (Seattle)	10	$150	NC	NC	NC	NC	NC	NC [4]	NC [5]	NC [6]	C
Health Insurance Plan (New York)	None	None	NC [7]	C	NC	NC	NC	C	C	C	-
Kaiser Plan (Northern California)	10	[8] $60	NC	NC	NC	NC	NC	C	C	C	NC
Kaiser Plan (Southern California)	10	[9] $100	NC	NC	NC	NC	NC	C	C	C	NC
Kaiser Plan (Oregon)	10	([10])	C [11]	C	C [11]	C [11]	NC	C	C	C	C [11]
Kaiser Plan (Hawaii)	None	None	NC	NC	NC	NC	NC	C	C	C [12]	C

C Covered.
NC Not covered.
[1] $50 deductible for hospital services.
[2] If for conditions which in the professional judgment of GHA doctors are subject to improvement through short-term treatment. Plan pays up to $15 per consultation for 16 consultations each year.
[3] Benefits are limited for surgery for congenital defects to gastro-intestinal anomalies, inquinal hernias, pilonidal cysts, and strabismus. For other congenital conditions, GHA will pay up to $250 toward the surgeon's fee. Hospital charges are covered.
[4] Plan excludes from coverage conditions under active treatment 60 days before coverage and conditions causing invalidism before date of coverage.
[5] Excluded if nontherapeutic.
[6] Except for infants born in Group Health Hospital eligible for coverage from birth.
[7] Plan excludes coverage of psychiatric disorders, after diagnosis, for which care is customarily provided by a psychiatrist.
[8] A $140 charge is applicable if confinement is due before 10 months continuous membership.
[9] A $175 charge is applicable if confinement is due before 10 months continuous membership.
[10] If confinement is due before 10 months continuous membership, there will be a charge of $120 in addition to specified supplemental charges.
[11] Plan pays up to an aggregate of $500 per calendar year (for both professional and hospital services). A 50-percent coinsurance is applicable.
[12] Covered upon payment of supplemental charges. In the case of self-paying groups and groups having less than 25 subscribers, congenital conditions are covered up to a maximum of $500 except that children born to plan members are fully covered.

TABLE 6–5.—Community group practice plans: Care outside plan area

Plan	Benefits
Community Health Association (Detroit)	Inpatient hospital care for 365 days in semiprivate accommodations. Outpatient care up to $60 per illness or accident. Inpatient medical and surgical care up to $250 per emergency accident or illness. Emergency first aid and necessary surgery within 24 hours of an accident.
Community Health Foundation (Cleveland)	An aggregate of $500 for emergency inpatient and outpatient hospital and medical services and ambulance service for emergency illness or accidental injury.[1]
Group Health Association, Inc. (D.C.)	After $75 deductible, full coverage of inpatient hospital services for 180 days per calendar year for acute illness or emergency surgery.[2] Up to $250 for each emergency surgical procedure;[3] $5 per day for physician service in nonsurgical cases; up to $15 for physician care outside the hospital for each emergency.
Group Health Cooperative (Seattle)	Emergency care up to $10,000 per case. Member pays $25 or 10 percent of first $555 of costs, whichever is greater, and 20 percent of costs above $555. Covers hospitalization, physician's services, and ambulance.
Health Insurance Plan (New York)	For emergency physician services, plan makes payments (according to New York Workmen's Compensation Schedule) up to $350 for each accident or injury.
Kaiser Plan (Northern California)	Service benefits for emergency care may be obtained through affiliated Kaiser plans. Otherwise, plan pays up to aggregate of $500 for care in emergency illness or accident. Covers inpatient and outpatient hospital aud medical services and ambulance service.[1]
Kaiser Plan (Southern California)	Service benefits for emergency care may be obtained through affiliated Kaiser plans. Otherwise, plan pays up to aggregate of $1,000 for care in emergency illness or accident. Covers inpatient and outpatient hospital and medical services and ambulance service.[1]
Kaiser Plan (Oregon)	Service benefits for necessary care may be received though affiliated Kaiser plans. For emergency illness or accident in other areas, plan pays up to $750. Covers inpatient and outpatient hospital and medical services and ambulance service.[1]
Kaiser Plan (Hawaii)	Service benefits for necessary care may be received through affiliated Kaiser plans. For emergency illness or accident in other areas, plan pays up to $2,000. Covers inpatient and outpatient hospital and medical services and ambulance service.[1]

[1] If the member obtains prior approval, a portion of the allowance may be applied toward the cost of necessary ambulance service or other special transportation arrangements medically required to transport the member to the service area for continuing or following treatment.

[2] Or when it is approved in advance by the GHA medical administrator.

[3] Or special situation arranged for by the GHA medical administrator or his representative.

Chapter 7

SUMMARY AND CONCLUSIONS

THE FOREGOING describes the benefits, limitations, and exclusions under health insurance coverages offered by the various types of health insurance organizations in 1968. The object has been: (a) to show what currently exists, and (b) to provide a benchmark by which change can be measured.

Summary of Existing Coverages

The coverages provided by the various groups of health insurance organizations have been briefly summarized at the end of each section and there is no point to a further recapitulation here.

Private health insurance in the United States mainly provides coverage of hospital care and of physicians' services associated with hospitalization. Coverage of other types of health care is much less extensive, both in terms of the number of people with some coverage and the proportion of charges met by insurance.

The number of persons under age 65 with some private health insurance coverage of the various cians' services, and 4 percent of expenditures for pital care, 36 percent of expenditures for physimet 70 percent of consumer expenditures for hosindicated by the fact that in 1967 health insurance

The degree of coverage of the various services is home care and to 3 percent for dental care.
The proportion drops to 10 percent for nursing-home visits or of prescribed drugs out of hospital. than half have any coverage of physician office and

Of those with some hospital protection, fewer in the accompanying tabulation.[1]
types of health care at the end of 1967 is shown

Type of health care	*Estimated number of covered persons under age 65 (in thousands)* [1]	*Percent of civilian population under age 65* [2]	*Persons covered for each service as a percent of those covered for hospital care*
Hospital care	153,768	86.5	100.0
Physician service:			
Surgical service	142,828	80.3	92.9
In-hospital visits	116,665	65.6	75.9
X-ray and laboratory examinations (out-of-hospital)	88,926	50.0	57.8
Office and home visits	75,785	42.6	49.3
Dental care	4,596	2.6	3.0
Prescribed drugs, out-of-hospital	69,363	39.0	45.1
Private duty nursing	73,857	41.5	48.0
Visiting nurse service	79,302	44.6	51.6
Nursing-home care	15,873	8.9	10.3

[1] The above data are based on enrollment reported by or for health insurance organizations, with deductions for duplicating or multiple coverages, i.e., coverages of a given service in excess of one held by any one person. These data are estimates and may overstate the extent of coverage. Data from household surveys indicate a lower coverage figure, namely, 134,000,000 persons for hospital care and 130,500,000 for surgery, or 75 and 74 percent, respectively, of the civilian population under age 65.
[2] Based on civilian population under age 65 of 177,801,000.

all other types of care.[2]

No picture of health insurance coverage at any given time is adequate unless it gives a sense of the degree of change and movement in this field. For all practical purposes, health insurance in the United States began in the 1930's with coverage of hospital care; shortly thereafter it was extended to cover surgical service and a little later in-hospital physician visits. Some 20 years ago the insurance

[1] Louis S. Reed and Willine Carr, "Private Health Insurance in the United States, 1967," *Social Security Bulletin*, February 1969. For 1968 figures, see Louis S. Reed, "Private Health Insurance, 1968: Enrollment, Coverage, and Financial Experience," *Social Security Bulletin*, December 1969.

[2] Dorothy P. Rice and Barbara Cooper, "National Health Expenditures, 1950–67," *Social Security Bulletin*, January 1969.

companies began to offer major medical coverages, built on the principle that all types of health care expenses contributing to potentially major or catastrophic illness costs should be covered. It was under these contracts that physician office and home visits, out-of-hospital drugs, appliances, and private duty nursing were first covered to any large extent.

In recent years change has continued at seemingly an accelerated pace. Blue Cross and the insurance companies have greatly improved their coverage of hospital care—coverage for 365 days is now common. Blue plan coverage of out-of-hospital X-ray and laboratory examinations has been greatly expanded. Blue Cross has considerably improved its coverage of mental illness, although in general the plans still provide markedly less benefits for mental than for general illness. Many Blue Shield plans have introduced "prevailing fee" or "reasonable and customary charge" programs and are thus providing full coverage of physician charges to some or all of their subscribers. Insurance companies also are experimenting with this under surgical insurance. Dental care insurance, although very limited, is now growing rapidly. Insurance coverage of vision care is beginning. Owing largely to the stimulus provided by Medicare, coverage of home health services and of care in extended care facilities and nursing homes is expanding.

Today there seems to be no type of health care that is not provided or covered to some degree by one or another type of health insurance organization, although no single health insurance organization by itself provides coverage of all types of health care.

Health insurance is a developing, evolving social art. If coverage of some services seems limited or sparse, it is well to bear in mind that 20 years ago many insurance spokesmen were still maintaining that some of the services now covered—doctors office and home visits, drugs, and dental care—were "uninsurable"—that coverage of their costs was neither desirable nor feasible.

Appraisal—A Standard of Health Insurance Coverage

What shall be said of today's coverages? Are they adequate? Do they meet the needs of the public? In what respects do they fall short?

No appraisal can be attempted unless one has in mind some concept or standard of what health insurance should be, of what coverage is needed by the public. On this, a consensus seems to be developing, but there is as yet no universal agreement. Nevertheless, an explicit statement, with which not all may agree, will be attempted.

The need for health insurance flows from, and is shaped by, the following considerations: (a) the need for averaging or spreading the risk of illness expense so that people may be protected against burdensome or catastrophic sickness costs; (b) the need for arrangements that will enable people to prepay the cost of health care and not have to postpone or go without care because of not having the funds on hand; (c) the need for arrangements that will encourage people to obtain preventive health care and care early in illness; and (d) the need for arrangements that will enable people to obtain medical care of high quality at reasonable cost. The implications of some of these statements require comment.

As regards the need for protection against burdensome or catastrophic illness expense, there is virtually no type of health care expense that by itself or in conjunction with other types of health care expense, cannot result in aggregate expenses of catastrophic proportions for people who comprise most of the population. Unexpected health care expenses of $2,000 may be catastrophic for a family with an income of $15,000 or $20,000 a year. Unexpected health care costs of $200 or $300 may be catastrophic for a family getting along on a tightly stretched income of $5,000.

These expenses are catastrophic for some in the sense that they are prohibitive, that people cannot pay them and therefore will go without needed care, or ask for private or public charity. They are catastrophic for others in the sense that they cannot be met out of current income without a substantial temporary reduction of the family's standard of living, or without forcing the family into debt, or using up accumulated savings.

The need for health insurance as a device to spread the risk of catastrophic medical expense fuses with the need for arrangements that enable people to prepay the cost of health care through

fixed periodic payments. Such arrangements, at least for people of low or moderate income who form the bulk of the population, give health care an assured place in the family's budget. They thus tend to give health care a higher priority in family expenditures than would otherwise be the case. Having paid for care in advance, as it were, people are encouraged to obtain health care as needed; cost at the time of service ceases to be a deterrent. Such arrangements maximize people's ability to pay for medical care.

The need for health insurance to maximize ability to pay for care also fuses with the need for arrangements that will encourage receipt of preventive care and care early in illness. In general, prepayment does this by removing or lowering the financial barriers. People are more likely to obtain a desirable health service if they have paid for it in advance and there is no substantial direct out-of-pocket cost.

The final need—that for arrangements that will promote or assure the effective and economical provision of high quality care—has many ramifications and is controversial. Up until recent years the prevailing opinion in this country has been that people were best served medically if they had free choice among physicians providing service on a fee basis. Hence, insurance that simply paid the cost of hospital care and all or most of the fees of physicians was all that was needed. A contrary opinion is held by those involved in the group practice prepayment plans. These persons believe that physicians can provide service most effectively and economically in a group practice setting, in which the group becomes responsible for the quality of care provided by each member.

In the final analysis, the aim of people in purchasing health insurance is to obtain high quality medical care when they need it. Furthermore, since cost is always an object and a limiting factor, they desire care at the lowest cost consistent with high quality. Health insurance therefore cannot be disassociated from quality of care or its effective and economical provision.

While these are the main considerations that go into the need for health insurance, other factors in the situation should be mentioned. First, health insurance as a device for spreading the risk of illness or for prepaying health care has a cost—what the insuring organization retains for its operating expenses, reserves, and net profits. As this cost, calculated as a percent of premiums or subscription costs, increases it erodes the advantages or benefits of health insurance.

From these considerations, a persuasive case could be made that all types of health care should be covered by insurance and without limit as regards duration of care or expense in any particular illness. For there is no type of health care not attended by expenses sufficiently large to cause some people to forego or postpone treatment.

Hospital care must be covered, but up to what limits in days or benefits? Virtually all existing coverage has limits—be it 120 days or 365 days per confinement, or specified maximum benefit amounts. No logical health-related defense of such limits on a continuing basis can be made. The person whose insurance protection has run out after he has been in the hospital 120 days or received $10,000 worth of care may still be bankrupted by the cost of additional care. Similarly, no logical defense can be made of covering hospital care for general illness and not covering it to the same degree for mental illness or tuberculosis.

The same considerations indicate that care in extended care facilities and nursing homes should be covered. For the individual who needs such care for himself or the members of his family, the cost can be overwhelming. Further, unless health insurance provides such coverage, some patients, simply because their insurance covers only the hospital bill, will be cared for in hospitals when they could be better and more economically served in extended care or nursing home facilities. As health insurance provides longer and fuller coverage of hospital stays, the need to provide insurance coverage of care in alternative facilities becomes more pressing.

There are problems in this area of distinguishing between need for health care and domiciliary care, and of whether people should pay part of the cost of long continued care in nursing homes when such care obviates the need for a home elsewhere, but these questions need not be dealt with here.

Similarly, full coverage of home health services is desirable because care at home may be better for the patient and may obviate the need for much more expensive care in a hospital.

As regards physician care, it used to be thought that coverage of surgical care and in-hospital visits would be sufficient, that patients could pay for care

in the office and home out-of-pocket. Now all recognize that coverage of physician service outside of the hospital is necessary. The expense can be burdensome; people will postpone care because of the fear of expense, and limitation of insurance protection to care in the hospital results in people coming into the hospital for diagnostic work-ups or care that could be provided as well and far less expensively on an outpatient basis.

Again, acceptance of the principle that physician care in the office and home should be covered does not preclude arrangements requiring patients to bear some part of the cost directly. The particulars of such arrangements need not be gone into here.

The same principles require insurance coverage of drug costs. The expense can be burdensome and more than some can afford. And of what use is a physican's diagnosis if the patient cannot afford the treatment prescribed? The same argument applies with respect to coverage of appliances, such as artificial limbs, braces, crutches, walkers, wheelchairs, rental of hospital type equipment for use at home, etc. In both instances, a requirement that patients pay a part of the cost directly may be desirable.

Dental care, which 10 or 15 years ago was considered uninsurable, is now increasingly being covered. Apparently the main reason is that people recognize the value of adequate dental care, and know that they will be much more apt to obtain it if they prepay part or all of the cost. There is a close relationship between family income and the amount of dental care that people receive—the relationship between ability to pay and receipt of care is closer than for any other type of health care. Dental insurance increases the ability of people to pay for dental care.

Vision care insurance—coverage of eye refraction examinations and eyeglasses—comes in the same category. The prepaid group practice plans have always provided eye refraction examinations as a necessary health service but generally have not furnished glasses on a prepayment basis. Now appreciable numbers of union welfare funds have developed programs for reimbursing the workers and their dependents for part of the cost of both the examinations and glasses. These arrangements occur most frequently in occupational groups in which good eyesight is particularly desirable, e.g., truck drivers. While the cost of eye refraction examinations and eyeglasses is not a particularly large one, nevertheless it may cause some to postpone or forego getting glasses. Again, people are more apt to get the care when needed if the expense is prepaid. Much the same can be said with respect to hearing aids, which are not yet covered under health insurance.

One final type of health care deserves mention—rehabilitation. This involves service or care additional to that dealt with above that may be needed to enable a person who has suffered the loss of a limb, an impairment, or a disability to make a maximum adjustment in terms of overcoming his handicap, caring for himself, and returning, if possible, to gainful employment. Such services or care would include training in the use of an artificial limb, physical and occupational therapy, reconditioning, psychological testing and evaluation to determine occupational potentialities, etc. The benefits of rehabilitation to the individual, his family, and society are tremendous. Certainly the health components of rehabilitation need health insurance coverage as much as any of the other types of health care dealt with here.

In short, comprehensive health insurance would include all needed health services and prescribed health supplies.[3]

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[3] At a special meeting of all Blue Shield plans held October 18, 1968, the plans adopted the report of a reference committee on the subject of a "Comprehensive Health Care Program." Dealing with the need to formalize Blue Shield's ability to underwrite comprehensive benefits, the committee recommended "that this Special Meeting establish the following as a comprehensive scope of benefits, to be available for purchase from or servicing by each Blue Shield plan not later than April 1, 1969 . . . :

"1. Surgery—including routine pre- and post-operative care and assistant at surgery
2. Anesthesia services
3. Radiation therapy—in and out of the hospital
4. Diagnostic X-ray in-hospital
5. Laboratory and pathology in-hospital
6. In-hospital medical care, including concurrent care
7. Pulmonary tuberculosis, mental disorders, drug addiction and alcoholism
8. Obstetrical care
9. Emergency treatment for accidental injury
10. Consultation
11. Out of hospital diagnostic X-ray and laboratory and pathological service
12. Physical therapy
13. Home and office
14. Newborn care

Continued on page 109.

The need for spreading the risk, of averaging and prepaying the cost and thus of maximizing ability to pay extends to all items of health care. It may be objected that the cost of comprehensive health insurance will be more than a considerable segment of the population can afford. Possibly so. But if persons of low income cannot afford comprehensive health insurance by how much less are they able to afford the cost of the different services and items of care without insurance? The problem becomes one of the ability of different stratas of the population to afford adequate health care.

It should not be inferred from this discussion that health insurance must necessarily cover the full cost of all health services. Arrangements whereby people pay directly an initial amount (deductible) of expense for certain or all services or pay a small proportion of the cost or a small fixed amount for each item of service, e.g., office visit or drug prescription, may or may not be desirable. All such arrangements, of course, lessen the degree of coverage. Obviously, they lessen the cost of the insurance but this may or may not be an object since people must pay the full cost of care in any event. The advantages of all such arrangements in encouraging prudent utilization of care and controlling charges or costs must be weighed in each instance against their disadvantages and against other methods of achieving these objectives.

CONCLUSIONS ON APPRAISAL

Judged by this standard, it is clear that all existing health insurance coverages—in greater or lesser degree—fall short. Most coverages are confined to a limited range of services and often cover these only partially; benefits for various services are subject to dollar or other limitations; certain illnesses or conditions are covered only partially or may be excluded from coverage altogether. In addition, some 17 to 25 percent of the population under age 65 have no private health insurance.

Private health insurance in 1967 met approximately one-third of consumer expenditures for personal health care (exclusive of the net cost of obtaining insurance).[4] The proportion would be three or four percentage points higher if expenditures for various items, which probably should not be covered by insurance, such as nonprescribed drugs, drug sundries, sunglasses, and the differential cost of private as opposed to semiprivate hospital accommodations, were excluded. If all of the population had comprehensive health insurance, such insurance would probably meet at least 90 percent of consumer expenditures for personal health services.

Reasons for Shortcomings of Existing Health Insurance Coverages

There are several reasons for the shortcomings and limitations of existing private health insurance.

One very important reason is that the general public is not fully aware of its health insurance needs. There is as yet very little public demand for some of the coverages, e.g., dental care, drugs, vision care, that fall within the standard discussed above. Public demand for comprehensive health insurance is growing, but only slowly.

Second, health insurance is, so to speak, an evolving art. Before a new coverage can be widely sold administrative techniques, methods of paying providers, feasible benefit packages, and data on probable utilization and costs must be developed. There must be experimentation, a process of trial and error. This takes time.

Continued from page 108.

15. Physical examinations
16. Out-patient psychiatric care
17. Inhalation therapy
18. Ambulance
19. Prosthetic appliances and orthopedic braces
20. Rental or purchase of durable equipment
21. Private duty nursing
22. Drugs
23. Dental
24. Vision care."

SOURCE: National Association of Blue Shield Plans Memorandum to Plans, October 18, 1968. NOTE: Hospital and nursing home care and home health services were presumably not listed because they are within the province of Blue Cross.

[4] Dorothy P. Rice and Barbara Cooper, "National Health Expenditures, 1950–67," *op. cit.*

A third reason has to do with custom, tradition, and inertia. Certain health insurance coverages have become well accepted by the public and health insurance organizations are used to, and skilled in, offering them. Only gradually are the limitations of these coverages recognized, and only gradually are new or broader coverages offered and accepted.

The development of group practice prepayment plans has progressed slowly because these plans involve fundamental changes in the traditional arrangements through which physicians render and patients receive service. There is some indication that attitudes and practices relating to group as contrasted with solo practice may be changing, however.

In some instances, existing legislation hampers or slows down experimentation. Insurance companies are free to offer new coverages as they will, but Blue Cross and Blue Shield plans generally operate under enabling acts that define the benefits they may offer; amendment of such legislation is frequently required before new types of benefits can be offered. However, once the plans have determined that they really wish to offer these new benefits, and when the endorsement of the hospitals and medical profession has been won, the desired legislation can generally be readily obtained.

A more serious legislative hurdle is the fact that existing legislation in many States does not sanction the establishment and operation of consumer sponsored group practice plans. Obtaining the necessary enabling legislation has up to now frequently been difficult, in many instances because of the opposition of the medical profession.

Many of the limitations of existing health insurance are due not to any reluctance or unwillingness of insurers to offer comprehensive coverage, but to the inability or unwillingness of the public to pay the costs involved. Blue Cross and Blue Shield plans are now willing to offer contracts providing fairly comprehensive coverage of most items of health care, but their most widely held contracts provide lesser benefits largely because of consumer unwillingness or inability to pay the cost. Insurance companies under their group policies are willing to provide any coverage that an employer, employee group, or union wants and is willing to pay for. They sell restricted coverages because that is what is effectively demanded.

Inasmuch as there are no existing health insurance plans that provide fully comprehensive coverage, one can only make a rough estimate of what such coverage would cost. The present charges for various segments of care give some indication, however. Thus, Group Health Association (Washington, D.C.) under the Federal Employees Health Benefit program provides complete coverage of general hospital care and virtually complete coverage of physician service at a total cost (including the Federal Government's contribution) of $17.59 per month for a single person and $44.87 for a family, or $211 and $538, respectively, on an annual basis.[5] This includes some slight coverage of prescribed drugs—80 percent in excess of $50 per person a year. It does not include full psychiatric care in office or hospital, nor any part of the cost of nursing-home care, dental care, and appliances. This plan covers service for which consumers, on the average, spend about 60 percent of their health dollar.

The comprehensive family dental plan of Group Health Dental Insurance in New York City may be used to get some idea of the cost of fairly comprehensive dental care. For its most comprehensive contract, providing full benefits for prosthetics, the premium is $4.55 per month for a single person and $18.90 for a family without orthodontia benefits, and $22.90 with orthodontia benefits.

A very rough estimate of the cost of complete out-of-hospital drug coverage would be in the neighborhood of $15 a year per capita for the population under age 65 and about $20 per capita for the total population, plus the cost of administration. These figures would suggest costs of perhaps $20 a year for a single person and $40 a year for a family.[6]

For the three coverages the aggregate costs would be in the neighborhood of $285 a year for a single person and $851 for a family.

A somewhat lower estimate of cost is achieved by using the subscription costs of Group Health Cooperative of Puget Sound. This plan provides to Federal employees under the FEHB program practically complete coverage of hospital care

[5] Rates effective for the year 1969.

[6] Estimate based upon data on per capita number of acquisitions of prescribed drugs and average cost per prescription. See *The Drug Users*, Task Force on Prescription Drugs, Background Papers, Office of The Secretary, U.S. Department of Health, Education, and Welfare (Washington: U.S. Government Printing Office, 1968) primarily pages 20 and 22.

(general hospital care only), physician service, and prescribed drugs for $14.15 a month for a single person and $31.33 for a family—$169.80 and $459.96 annually (1969 rates). Adding the GHDI subscription costs for its comprehensive plan, one obtains an annual figure of $224 for a single person and $733 for a family.

One may compare these estimates with the total annual costs under the high option of the Government-Wide Service Benefit Plan for Federal Employees of $173 for a single person and $423 for a family, and the total charges under the high option of the Government-Wide Indemnity Plan of $183 and $453, respectively (1969 rates). Both plans probably meet no more than 50 percent of total health costs, if that.

Considering the distribution of the population by income level, it is apparent that a significant portion of the population is unable to afford comprehensive health insurance, or, for that matter, adequate health care, if the entire cost must come from their own current incomes.

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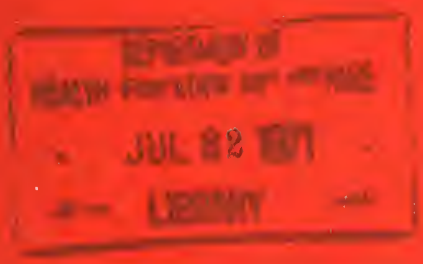
HEALTH INSURANCE PLANS OTHER THAN BLUE CROSS OR BLUE SHIELD PLANS OR INSURANCE COMPANIES



U.S. DEPARTMENT OF
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SOCIAL SECURITY ADMINISTRATION
OFFICE OF RESEARCH AND STATISTICS
Research Report No. 35

Health Insurance Plans Other than Blue Cross or Blue Shield Plans or Insurance Companies

1970 Survey

by Louis S. Reed
assisted by Maureen Dwyer

U.S. DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
SOCIAL SECURITY ADMINISTRATION
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FOREWORD

THIS REPORT gives the results of a survey undertaken in 1969 of all health insurance plans of this type known to the Office of Research and Statistics of the Social Security Administration.

These plans constitute a small but highly significant segment of private health insurance in the United States. The Office of Research and Statistics has been conducting surveys of these plans (formerly called "independent plans") since 1943 and these surveys are the only source of national data on health insurance organizations of this character.

The survey was made and the report written by Louis S. Reed with the assistance of Maureen Dwyer.

IDA C. MERRIAM,
Assistant Commissioner for Research and Statistics.

MARCH 1971.

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I. INTRODUCTION

THIS REPORT gives the findings of a survey, conducted in the spring and early summer of 1969 by the Office of Research and Statistics of the Social Security Administration, of all private health insurance plans in the United States other than Blue Cross plans, Blue Shield plans, or insurance companies. (Formerly these plans were called "Independent Health Insurance Plans," but that title has become progressively inappropriate and has been discarded.)

The Office of Research and Statistics has been making surveys of health insurance plans of this category for more than 25 years. The last full survey was made in 1965 to obtain data for 1964.[1] Earlier surveys of all known plans were made in, or obtained data relating to, 1943, 1949, 1953, 1956, 1959, and 1961.[2] In recent years surveys have been made in each of the intervening years of a small number of the larger plans so as to provide a basis for annual estimates of the number of persons served by, and the income and expenses of all organizations of this nature.[3] ORS is the sole source of comprehensive national information on the number of persons served by these organizations, the services or benefits provided, and their income and benefit and operating expenses.

Health insurance plans or organizations other than Blue Cross or Blue Shield plans and insurance companies comprise a small

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[1] Louis S. Reed, Arne H. Anderson and Ruth S. Hanft, *Independent Health Insurance Plans in the United States, 1965 Survey,* Research Report No. 17, Office of Research and Statistics, Social Security Administration, 1966.

[2] See Margaret C. Klem, Prepayment Medical Care Organizations, Bureau of Research and Statistics, Social Security Board, Bureau Memorandum No. 55 (published in three editions from 1943–45); Agnes W. Brewster, *Independent Plans Providing Medical Care and Hospitalization Insurance in 1949 in the United States,* Division of Research and Statistics, Social Security Administration, Bureau Memorandum No. 72, 1952; Agnes W. Brewster, "Independent Plans Providing Medical Care and Hospital Insurance, 1954 Survey," *Social Security Bulletin,* April 1955; same author and same title but "1957 Survey," *Social Security Bulletin,* April 1958; same author and same title but "1959 Survey," *Social Security Bulletin,* February 1961; and Donald G. Hay, Louis S. Reed and Robert E. Melia, "Independent Health Insurance Plans in the United States—1961," *Research Report No. 2,* Division of Research and Statistics, Social Security Administration, 1963.

[3] These annual estimates have been set forth in ORS Research and Statistics Notes. For illustration see Louis S. Reed and Willine Carr, "Independent Health Insurance Plans in 1967," Research and Statistics Note No. 16—1968, and same authors, "Independent Health Insurance Plans in 1968, Preliminary Estimates," Note No. 17—1969.

but significant segment of private health insurance in the United States. They provide some coverage of hospital care to approximately 4 percent of all persons in the country who have any coverage of hospital care through private health insurance, some surgical coverage to 5 percent of those with any surgical coverage, some coverage of physician office and home visits to 9 percent of the persons with any coverage of this service, and some coverage of dental care to 46 percent of the persons with any coverage of this type of care. The aggregate expenditures of these organizations for health care benefits amounted in 1968 to approximately 6 percent of the total benefit expenditures of all private health insurance organizations in the United States.[4]

TYPES OF PLANS

Health insurance plans or organizations other than Blue Cross and Blue Shield plans or insurance companies are of two main types: (1) those which offer health services or health care benefits on a prepayment or insurance basis to the subscribing public of their general area; and (2) health benefit programs of welfare funds, employers, employee benefit associations, or unions, which provide one or more types of health care benefits on a self-insured basis (as opposed to the purchase of coverage from a Blue Cross or Blue Shield plan, an insurance company, or a community plan of the type dealt with in this report) to a defined group of employees or union members and, in most cases, their dependents. These self-insured employer-employee-union plans constitute about 87 percent of all plans of this nature and serve close to half of the total number of persons served by all plans.

The plans or organizations may also be classified into two main groups on another basis: (1) those that provide physician service or dental care mainly or entirely through group practice units of physicians or dentists; and (2) those that provide services or benefits mainly or entirely on a free choice of physician (or dentist), fee-for-service basis.

The plans can additionally be classified according to the nature of the organization that sponsors them and elects or appoints the controlling board or the administrative head. Among the various types of sponsorship are: (a) a group of consumers, i.e., the persons served; (b) a community nonprofit group with a board of directors composed of individuals selected to represent various sectors of the general community, including the persons served;

[4] See Louis S. Reed, "Private Health Insurance, 1968: Enrollment, Coverage, and Financial Experience," *Social Security Bulletin*, December, 1969. The above figures are from the findings of this survey related to the totals for all health insurance organizations as set forth in the article.

(c) a small group of persons who own the plan and operate it for their private profit; (d) a union-employer welfare fund, employer, employee benefit association, or union, as indicated above; (e) a State or local medical society or dental society; (f) a private group clinic of physicians and (g) a private group clinic of dentists.

To classify plans or organizations into all these groups and subgroups would be cumbersome. This report classifies the plans into seven main types:

1. Community group practice
2. Community individual practice
3. Employer-employee-union group practice
4. Employer-employee-union individual practice
5. Private group medical clinic
6. Private group dental clinic
7. Dental service corporation (sponsored by dental society)

DESCRIPTION OF TYPES OF PLANS

COMMUNITY GROUP PRACTICE PLANS

These are plans that serve the general population of the community in which they are located and provide services through organized group practice units of physicians. Virtually all of the plans provide comprehensive physician service, i.e., service in the office or clinic, home and hospital. Service is provided primarily by a salaried staff of physicians or through groups of physicians, organized as partnerships or corporate associations, with which the plan contracts for service. Subscribers may obtain service within the area only from the plan's medical group or groups.

All plans are organized on a nonprofit basis. Most are controlled by boards of directors selected to represent the general community and/or the subscribers.

There were 23 plans of this nature included in the tabulations of this report. They are listed in appendix A which lists all plans included in the survey, by type of plan and State.[5] Among the larger and better known of these plans are the Kaiser Foundation Health Plans of Northern and Southern California, Oregon, Hawaii, and Cleveland, Ohio. A Kaiser plan of this nature was started in Denver, Colorado in January 1969, but is not included in the tabulations since it was not in operation in 1968. Other large and well known community group practice plans are the Health Insurance Plan of Greater New York (New York City);

[5] This listing includes a few additional plans that were not included in the tabulations. Some of these commenced operation after 1968; others did not respond to the survey or did not provide sufficient data about themselves.

Group Health Cooperative of Puget Sound (Seattle, Washington); Community Health Association (Detroit, Michigan); and Group Health Association (Washington, D.C.).[6]

Community group practice plans are different from almost all the other plans dealt with in this report in that they directly provide service to a group of subscribers through their own salaried staffs of physicians or groups of physicians with whom they contract. Here the group of physicians, in effect, assumes responsibility for the health care of a defined group of people. The position and prospects of these organizations in the medical scene are matters of controversy. Some see them as "the wave of the future." Others find defects in their mode of organization and operation which preclude great growth in the future. The organizations are growing in number and population served, but rather slowly.[6]

COMMUNITY INDIVIDUAL PRACTICE PLANS

These plans serve the general community of the area in which they are located. A few provide hospital care only. The others provide physician (or dental) benefits on a free choice, fee-for-service basis. That is, subscribers have free choice of private practitioners in the area and the plans pay these directly on a fee basis or reimburse subscribers for charges incurred in accordance with a schedule of allowances.

Seventeen community individual practice plans were included in the 1969 survey. (See appendix A for list.) The largest, by all odds, is Group Health Insurance, Inc. of New York City, which at the end of 1968 had 1,110,000 subscribers.

Most of these plans are organized or sponsored by community or consumer groups. However, the group includes three plans sponsored by medical societies only one of which, the Foundation for Medical Care of San Joaquin County, California, is of significant size.[7] They were included here rather than in a separate

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[6] Appendix C provides a brief description of each of the principal plans of this type. These nine plans have over 95 percent of the enrollment in all community group practice plans. Data on enrollment and income over the period 1950–68 are also furnished. For detailed information on contracts offered and subscription rates, see Louis S. Reed and Willine Carr, *Benefit Structure of Private Health Insurance, 1968*, Research Report No. 32, Office of Research and Statistics, Social Security Administration, 1970.

[7] The San Joaquin Plan is one of a number of so-called Foundation Medical Care Plans operating in California that serve the general public on a free choice, fee-for-service basis. All are controlled by medical societies. They are not included here because all with the exception of the San Joaquin Plan are underwritten by insurance companies. The San Joaquin Plan also is underwritten by an insurance company for most of its business, but is self-insured as regards Federal employees covered under the Federal Employee Health Benefits program, but it insures hospital care benefits for this group with an insurance company. Hence, this plan comes into the survey for its Federal employee subscribers for benefits other than hospital care.

group of their own because there are so few of them. The group includes five plans which provide only hospital care; most of them are similar in organization and operation to Blue Cross plans. The group includes one plan which to all intents and purposes is an insurance company; it is included because, being organized under a State law providing for health contractors, it is not counted as an insurance company. Obviously, this group of community individual practice plans is a sort of catchall that includes plans of quite diverse nature and control.

EMPLOYER-EMPLOYEE-UNION GROUP PRACTICE PLANS

These are health benefit plans operated by jointly managed union-employer welfare funds, employers, employee benefit associations or unions which provide medical and/or dental service wholly or mainly through group practice, i.e., through health centers staffed by salaried physicians and/or dentists or through contract with a group clinic of physicians or dentists. All told, there are some 102 plans of this nature (including one in Puerto Rico). The great majority are operated by jointly managed welfare funds, i.e., funds financed in whole or in part by employer contributions and which under Federal legislation must be managed by trustees appointed in equal numbers by the union and the employer or employers.[8]

All of these employer-employee-union plans serve a designated group of employees or union members and, in most cases, their dependents.

Many employer-employee-union group practice programs (and the same can be said of those that provide benefits through individual practice) purchase insurance coverage of certain services from Blue Cross, Blue Shield, or an insurance company. They enter into this survey only as regards benefits for which they self-insure.

EMPLOYER-EMPLOYEE-UNION INDIVIDUAL PRACTICE PLANS

These are similarly organized programs which, however, provide medical and/or dental service wholly or mainly through individual practice, i.e., covered persons have free choice of physician and/or dentist and are reimbursed, in whole or in part, for charges incurred. There are 322 plans of this type, including five in Puerto Rico. Many of them insure for various health benefits with a carrier; self-insurance for other benefits brings them into the survey.

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[8] However, union welfare funds established prior to the 1947 enactment of the governing Federal legislation (the Taft-Hartley Act) need not have employer trustees.

PRIVATE GROUP MEDICAL CLINIC PLANS

These are plans in which a group of physicians, organized as a private clinic, provides service to one or more groups of persons (usually employee groups) on a prepayment basis.[9] Eleven plans of this nature were included in the survey. The largest and best known of these plans is the Ross-Loos Medical Group of Los Angeles. This medical group provides almost all of its service on a prepayment basis. However, many, perhaps most, of the other group clinics serve patients mainly on a fee-for-service basis, and the prepayment program is only a minor portion of their total practice.

PRIVATE GROUP DENTAL CLINICS

These are similar to the private medical group prepayment plans, but are operated by a group clinic of dentists. Only three such plans were included in the survey. As in the case of private medical group clinics, the dental clinics serve many or most of their patients on a fee-for-service basis, the income from the prepayment program being the smaller share of the total.

DENTAL SERVICE CORPORATION PLANS

These are plans sponsored by State dental societies, which provide dental care to groups of subscribers on a prepayment basis. The plans are analogous to the Blue Shield medical service plans. Some 17 dental service corporatons that were active in 1968 are listed in appendix A. However, only 10 of these are included in the survey; the rest did not provide sufficiently complete enrollment or financial data to be included.

METHOD OF SURVEY

In April 1969, survey letters were addressed to all plans or organizations known to ORS to provide health care benefits on a prepayment or insurance basis that were not a Blue Cross or Blue Shield plan or an insurance company. The letter explained the purposes of the survey, enclosed a reprint showing the use of the data being collected, and requested the organization, if it fell within the terms of the survey, to complete and return the enclosed questionnaire and to send along copies of brochures, annual report, financial statement and other material describing its program. If the organization believed that it did not come within the scope of the survey, it was urged to so inform ORS. Appendix B reproduces the questionnaire and letter.

[9] Mainly these groups are organized as partnerships; some are incorporated. A few may be owned primarily by one or two physicians who employ the other physicians on a salaried basis.

DEVELOPMENT OF LIST OF PLANS CONTACTED

Considerable effort was devoted to developing as complete a list as possible of all plans or organizations that might come within the scope of the survey. The main group of plans on the mailing list consisted of those which responded in the 1965 survey. This list has been kept up-to-date by addition of newly organized plans of which information had been received and deletion of organizations known to have gone out of existence or to have changed character so that they no longer came within the scope of the survey.[10] Also included were plans that were on the mailing list in the 1965 survey, but had not responded in that survey. Few of these responded in this survey, or if they did, it was to state that they had taken out insurance with a carrier and hence did not come within the scope of the survey.

It was thought that most Blue Cross and Blue Shield plans would know of any competing plans in their area serving the general public, and any sizable employer-employee-union organizations that self-insured for hospital or physician care benefits. Hence, letters were sent to all Blue Cross and Blue Shield plans enclosing a copy of the report of the 1965 survey which contained a list, by State, of plans included in that survey and asking them to provide ORS with the names and addresses of any other plans in their area of which they had knowledge. A followup letter urging cooperation was sent by the Blue Cross and Blue Shield national associations to all plans that did not respond initially. Ultimately, replies were received from 80 percent of all Blue Cross and Blue Shield organizations. Approximately half of these reported that they knew of no other plans in their area than those listed in the directory; half provided the names and addresses of additional organizations. Some noted organizations that should be deleted.

The Group Health Association of America provided the names of a few group practice plans not already known to ORS. The American Medical Association provided a list of medical groups with prepayment plans, derived from its 1965 survey of medical groups in the United States.[11]

A list of medical clinics reported to have clinic-sponsored prepaid medical care plans was culled from a directory of medical

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[10] e.g., employer-employee-union organizations that formerly self-insured for health care benefits but changed to insurance through Blue Cross, Blue Shield or an insurance company.

[11] The Association found that there were 88 groups with prepayment plans. This count included community group practice plans, employer-employee-union plans providing service through group practice and private medical group clinics. See *Survey of Medical Groups in the United States, 1965*, Special Statistical Series, Department of Survey Research, American Medical Association, Chicago, 1968.

groups published by the Medical Group Management Asociation.[12] (The directory seems to have been in error in some cases since some of these clinics promptly reported that they had no prepaid plan.)

A few names of plans not already known were obtained from the California Medical Association. An up-to-date list of self-insured hospital-medical plans for railroad employees was obtained from the Association of Railway Medical Service Executives.

A considerable number of names of plans providing dental benefits was obtained from the Division of Dental Health of the Bureau of Health Professions Education and Manpower Training of the National Institutes of Health. These names came from the Division's periodic surveys of dental prepayment plans. A list of dental service corporation plans sponsored by dental societies was obtained from the National Association of Dental Service Plans, affiliated with the American Dental Association.

A list of jointly trusted employee (union) welfare funds in New York State which provided some form of health benefits through self-insurance was provided by the New York State Department of Insurance. A significant number of these funds furnished only optical benefits by self-insurance, all other benefits being provided through insurance.

One source of names of plans drawn on in the 1965 survey was not available for this survey. In 1965 the Office of Labor Management and Welfare-Pension Reports of the U.S. Department of Labor provided to ORS a list of self-insured welfare and pension plans which provided some health care benefits. (This listing was derived from reports of employers, welfare funds and unions under the Welfare and Pension Plans Disclosure Act.) Unfortunately, this agency could not develop an up-to-date similar listing in time to be useful in this survey.

SURVEY PROCEDURES AND EXTENT OF RESPONSE

The first mailing of questionnaires was made in April 1969. A followup mailing was made to nonrespondents about a month later and a second followup in another month or so. As in the case of the 1965 survey, particular attention was paid to plans with more than 20,000 participants and, through special letters and telephone calls, replies eventually were received from all of these.

The questionnaire responses and accompanying material (brochures describing plan benefits, annual reports, financial statements, etc.) were carefully scrutinized to make sure that the organization came within the scope of the survey, i.e., that it was

[12] International Directory of the Medical Group Management Association, 1968.

not a Blue Cross or Blue Shield plan, or an insurance company and that its benefits were not provided through insurance with Blue Cross, Blue Shield, an insurance company or other carrier. Tabulation of questionnaires was begun at the end of October 1969. No questionnaire received after that time was included.

All told, letters were sent to 1,380 organizations. The Postal Service was unable to locate 43 of these. Replies were received from 920 organizations. Of these, 488 came within the scope of the survey, provided usable information, met the minimum size eligibility test, and were included in the tabulations. Replies from an additional two plans came in too late to be included in the tabulations. Of the 432 respondents not included in the survey, the vast majority were welfare funds, employers, employee associations and unions who stated, or whose questionnaire and accompanying material indicated, that they did not self-insure for any health benefits. Some were private medical clinics who reported that they had no clinic sponsored prepayment plan. A few did not provide sufficient information so that their questionnaires could be used. A small number were excluded because they were of insignificant size—they covered less than 50 persons or had benefit expenditures of less than $1,000.

Of the 432 respondents not included in the survey, 113 were organizations that had been included in the 1965 survey, but no longer came within the scope of the survey. Almost all were employer-employee-union organizations who had shifted from self-insurance to insurance with Blue Cross-Blue Shield or an insurance company.

A number of plans stated that dependents were covered, but they did not know the number of covered dependents. In this case, the number of dependents was estimated by assuming one and one-half dependent per subscriber or employee covered.

The number of plans included in the 1969 survey was about 100 less than the number included in the 1965 survey. The main explanation is the many employer-employee-union organizations that shifted from self-insurance to insurance through a carrier. A further indication of the same trend is the very considerable number of employer-employee-union organizations that self-insured for only minor benefits, such as drugs or vision care, but insured all hospital and physician benefits with a carrier.

A list of the 488 plans that are included in the tabulations of this report is given in appendix A, which lists the plans by type and alphabetically within each State, with code designations indicating the types of benefits provided. Six of the 488 plans included in the survey were in Puerto Rico.

The list given in appendix A includes the names of 504 organizations. The difference is accounted for by the inclusion of a few plans that began operation only in 1969, or did not provide usable information on enrollment or finances, or whose replies came in too late, etc.

It is obvious that there are other organizations of the type surveyed that were not included in this survey because their existence was not known to ORS or they did not choose to respond. The size of the total universe of all plans or organizations of this nature is a matter of conjecture. The author is of the opinion that if all plans or organizations of this nature were reached and had responded, the total number of persons covered as shown in this report would be increased by less than 10 percent, and the income and benefit expenditure by a still smaller percentage.

II. PLANS, ENROLLMENT, AND SERVICES COVERED

PLANS AND ENROLLMENT

THE 482 PLANS in the United States (exclusive of Puerto Rico) dealt with in this report had a total gross enrollment for any type of benefit at the end of 1968 of 12,204,000 persons (table 1).[1] This enrollment does not necessarily consist of different persons since a person might be enrolled, say, in both a community group practice plan and a dental service prepayment plan. However, the extent of such multiple enrollment is probably quite small.

The majority of the plans—87 percent—are employer-employee-union organizations that self-insure for one or more health benefits; these plans had almost half—48 percent—of the total enrollment for any benefit. The 23 community group practice

TABLE 1.—Number of plans and enrollment

Type of plan	Plans		Enrollment		Average enrollment per plan
	Number	Percentage distribution	Number (in thousands)	Percentage distribution	
All plans	482	100.0	12,203.5	100.0	25,318
Community group practice	23	4.8	2,883.5	23.6	125,370
Community individual practice	17	3.5	1,807.1	14.8	106,300
Employer-employee-union group practice	101	20.9	1,638.3	13.4	16,221
Union-employer welfare fund	45	9.3	1,044.4	8.5	23,209
Employer or employer association	21	4.4	63.5	.5	3,024
Union	7	1.4	89.0	.8	12,714
Employee association	13	2.7	243.3	2.0	18,715
Employer-employee association	15	3.1	198.1	1.6	13,207
Employer-employee-union individual practice	317	65.8	4,195.8	34.4	13,236
Union-employer welfare fund	149	30.9	1,879.8	15.4	12,616
Employer or employer association	70	14.5	858.3	7.1	12,261
Union	11	2.3	1,116.0	9.1	101,455
Employee association	43	8.9	211.0	1.7	4,907
Employer-employee association	44	9.2	130.7	1.1	2,970
Private group medical clinic	11	2.3	149.7	1.2	13,609
Private group dental clinic	3	0.6	42.8	.4	14,267
Dental service corporations	10	2.1	1,486.3	12.2	148,630

[1] Data on the six plans in Puerto Rico are given in appendix F. There are no plans of this character, so far as known, in the Virgin Islands, Guam, and other outlying territories.

plans constitute only 5 percent of the total number of plans but had almost one-quarter of the total enrollment. The 17 community individual practice plans (which are diverse in nature and cover varied services) were 4 percent of the total number of plans but had 15 percent of the total enrollment.

Of the 418 employer-employee-union plans, about a quarter with approximately the same proportion of the total enrollment in such plans provided medical and/or dental service mainly through group practice arrangements; the rest through individual practice.[2] Among the employer-employee-union group practice plans, those operated by jointly managed union employer welfare funds constitute almost half of the total and have well over half of the total enrollment in all plans of this type. The next most numerous are plans operated by individual employers (or rarely, associations of employers) but they cover only a small number of persons. From the standpoint of enrollment, the next most important types of plans are those run by employee benefit associations and employer-employee associations which together have an enrollment of over 400,000 persons. (The great majority of these are railway employees served by the railway hospital associations.)

Similarly among the employer-employee-union individual practice plans, those operated by welfare funds constitute almost half of the total and have over 40 percent of the total enrollment in such plans. Next most numerous are the plans of employers or employer associations which serve over 800,000 persons. Individual practice plans operated by unions are small in number—only 11—but they serve over 1,100,000 persons. Plans operated by employee benefit associations or jointly by employers and employee associations are fairly numerous (87 all told) but serve a relatively small number of persons.

The relatively small number of plans operated wholly by unions, as compared with plans operated by jointly managed (union-employer) welfare funds, is explained mainly by the fact that under existing Federal legislation a union cannot receive employer contributions for its benefit program unless such contributions go to a jointly managed welfare fund. From a tax standpoint, it is advantageous for workers to have benefit programs financed by employer contributions (which are business expenses for the employer) rather than by employee or union member contributions paid out of taxable income. The larger union individual practice

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[2] Most of those that provided physician service mainly through group practice were welfare funds that maintained a health center which provided physician service at the center with surgery and in-hospital visits provided through individual practice (i.e., allowances against charges of individual practitioners) or through insurance with Blue Shield or an insurance company.

plans are those of Federal employee organizations that serve Federal employees and their dependents under the Federal Employee Health Benefits program; Federal Government contributions to those plans are allowable.

The 11 private group medical clinic plans served about 150,000 persons—less than 1 percent of the total served by all plans. The three private group dental clinic plans had an enrollment of 43,000 persons. The 10 dental service corporations served almost a million and a half persons or about 12 percent of the total enrolled for any benefit.

Adding the community group practice plans, the employer-employee-union group practice plans, the private group medical clinics, and the private group dental clinics gives a total of 28 percent of all plans, with 38 percent of the total enrollment, that provide physician care and/or dental care mainly through group practice.

Table 1 also shows the average enrollment per plan. These figures can be misleading since the average enrollment in many cases does not represent the typical, if any, case. For all of the plans, the average number of persons covered is about 25,000. The average enrollment is largest for the dental service corporations (149,000 persons). Next in average size are the community group practice plans (125,000 persons) closely followed by the community individual practice plans (106,000 persons). The employer-employee-union programs, whether providing service through group practice or individual practice, are relatively small. Welfare funds providing care mainly through group practice have an average enrollment of 23,000 persons. The other types of organizations in this group are much smaller on the average.

The employer-employee-union plans providing benefits mainly through individual practice cover 13,000 persons on the average. The largest organizations are the 11 union programs with an average enrollment of 101,000. The average size of employee and employer-employee benefit associations is quite small.

Private group medical clinic and private group dental clinic plans both serve relatively small numbers of persons—about 14,000 in both cases. Among the private group medical clinics, there is one large plan, the Ross-Loos Medical Group of Los Angeles, California. This brings up the average; most of the other plans are quite small. In some cases the prepayment program of these clinics is small in relation to the clinic's total practice.

COVERAGE OF DEPENDENTS

Among the larger plans serving the general community, coverage of dependents is virtually universal. Among the employer-employee-union plans, especially those providing care mainly through

group practice, coverage of dependents is by no means universal; in fact while a majority of the employer-employee-union group practice plans cover dependents, only 40 percent of the employees served by these plans are in those that cover dependents (see table 2).

All of the significant community group practice plans serve dependents. The same holds for the community individual practice plans. Of the employer-employee-union group practice plans, two-thirds serve dependents. However, many of the larger plans do not and of the 988,000 employees served by all plans of this nature, only 381,000 are in plans that provide care to dependents. It is mainly the plans operated by welfare funds and by employee or employer-employee associations that do not cover dependents and, primarily, the figures reflect the labor health centers maintained by various unions and the railway employee hospital associations. These latter, some of them more than a hundred years old, were established to provide care to sick or injured employees and with one or two exceptions have never served dependents.

Over two-thirds of the employer-employee-union individual practice plans serve dependents and three-quarters of all employees covered by these plans are in plans that provide benefits to dependents. Again, it is the employee or employer-employee associations plans—in terms of enrollment—that mainly do not serve dependents.

All except one of the private group medical clinic plans serve dependents and all of the private group dental clinic and dental service corporation plans do.

Of the total persons served by all plans, 40 percent are subscribers-employees-annuitants and 60 percent are dependents. For the community group practice plans the ratio is 38 percent subscribers and 62 percent dependents, which is virtually the same as under Blue Cross-Blue Shield and insurance company group coverages where 36–37 percent are subscribers-employees and 64–63 percent dependents. The ratio of dependents to the total is at a somewhat higher level in the dental clinic and dental service corporation plans, suggesting that these plans are especially attractive to families with children.

SIZE OF PLANS

Table 3 provides information on the size of plans. They run the gamut from quite small to quite large, but the great majority cover a rather small number of persons. Thus, approximately a third of all plans cover less than 1,000 persons and 60 percent cover less than 5,000. Only 8 percent of the plans cover more than 50,000 persons.

TABLE 2.—Plans covering dependents, their enrollment; and number of subscriber-employees and dependents covered

Type of plan	Plans			Subscriber-employees covered			Total enrollment		
	Total	Covering dependents		Total (in thousands)	In plans covering dependents		Total (in thousands)	Dependents (in thousands)	Dependents as percent of total
		Number	Percent of total		Number (in thousands)	Percent of total			
All plans	482	337	70.0	4,899.8	3,874.4	79.1	12,203.5	7,303.7	59.8
Community group practice	23	18	78.3	1,092.4	1,083.2	99.1	2,883.5	1,791.1	62.1
Community individual practice	17	14	82.3	729.5	723.7	99.2	1,807.1	1,077.6	59.6
Employer-employee-union group practice	101	67	66.3	988.0	381.4	38.6	1,638.3	650.3	39.7
Union-employer welfare fund	45	29	64.4	623.5	253.3	40.6	1,044.4	420.9	40.3
Employer or employer association	21	19	90.5	26.7	23.4	87.6	63.5	36.8	57.9
Union	7	7	100.0	30.5	30.5	100.0	89.0	58.5	65.7
Employee association	13	4	30.8	184.5	25.1	13.6	243.3	58.8	24.2
Employer-employee association	15	8	53.3	122.8	49.1	40.0	198.1	75.3	38.0
Employer-employee-union individual practice	317	215	67.8	1,597.7	1,195.9	74.9	4,195.8	2,598.1	61.9
Union-employer welfare fund	149	96	64.4	770.7	545.0	70.7	1,879.8	1,109.1	59.0
Employer or employer association	70	58	82.9	288.7	258.4	89.5	858.3	569.6	66.4
Union	11	8	72.7	347.6	304.1	87.5	1,116.0	768.4	68.8
Employee association	43	22	51.2	124.5	62.8	50.4	211.0	86.5	41.0
Employer-employee association	44	31	70.4	66.2	25.6	38.7	130.7	64.5	49.3
Private group medical clinic	11	10	90.9	51.2	49.2	96.3	149.7	98.5	65.8
Private group dental clinic	3	3	100.0	13.8	13.8	100.0	42.8	29.0	67.7
Dental service corporations	10	10	100.0	427.2	427.2	100.0	1,486.3	1,059.1	71.3

TABLE 3.—Plans by size of enrollment

Type of plan	Total	Under 1,000	1,000–4,999	5,000–9,999	10,000–24,999	25,000–49,999	50,000–99,999	100,000–499,999	500,000–999,999	1,000,000 or more
	Number of plans									
All plans	482	158	134	61	57	32	18	16	4	2
Community group practice	23	1	9	3	1	1	3	2	3	----
Community individual practice	17	3	4	2	3	----	2	2	----	1
Employer-employee-union group practice	101	13	32	15	18	17	5	1	----	----
Union-employer welfare fund	45	2	13	6	10	9	4	1	----	----
Employer or employer association	21	6	11	3	1	----	----	----	----	----
Union	7	2	1	1	1	2	----	----	----	----
Employee association	13	----	3	3	3	3	1	----	----	----
Employer-employee association	15	3	4	2	3	3	----	----	----	----
Employer-employee-union individual practice	317	135	83	36	34	12	7	9	1	----
Union employer welfare fund	149	44	45	24	22	7	3	4	----	----
Employer or employer association	70	46	9	3	6	2	1	3	----	----
Union	11	3	1	1	----	1	2	2	1	----
Employee association	43	13	21	4	3	1	1	----	----	----
Employer-employee association	44	29	7	4	3	1	----	----	----	----
Private group medical clinic	11	2	4	3	1	----	----	1	----	----
Private group dental clinic	3	----	----	2	----	1	----	----	----	----
Dental service corporation	10	4	2	----	----	1	1	1	----	1
	Percentage distribution									
All plans	100.0	32.8	27.8	12.7	11.8	6.7	3.7	3.3	0.8	0.4
Community group practice	100.0	4.4	39.1	13.0	4.4	4.4	13.0	8.7	13.0	----
Community individual practice	100.0	17.6	23.5	11.8	17.6	----	11.8	11.8	----	5.9
Employer-employee-union group practice	100.0	12.9	31.7	14.8	17.8	16.8	5.0	1.0	----	----
Union-employer welfare fund	100.0	4.5	28.9	13.3	22.2	20.0	8.9	2.2	----	----
Employer or employer association	100.0	28.6	52.4	14.3	4.7	----	----	----	----	----
Union	100.0	28.6	14.3	14.3	14.3	28.6	----	----	----	----
Employee association	100.0	----	23.1	23.1	23.1	23.1	7.6	----	----	----
Employer-employee association	100.0	20.0	26.7	13.3	20.0	20.0	----	----	----	----

mployer-employee-union individual practice	100.0	42.6	26.2	11.4	10.7	3.8	2.2	2.8	.3
Union-employer welfare fund	100.0	29.5	30.2	16.1	14.8	4.7	2.0	2.7	
Employer or employer association	100.0	65.7	12.8	4.3	8.6	2.9	1.4	4.3	
Union	100.0	27.2	9.1	9.1		9.1	18.2	18.2	9.1
Employee association	100.0	30.3	48.8	9.3	7.0	2.3	2.3		
Employer-employee association	100.0	65.9	15.9	9.1	6.8	2.3			
Private group medical clinic	100.0	18.2	36.3	27.3	9.1			9.1	
Private group dental clinic	100.0			66.7		33.3			
Dental service corporation	100.0	40.0	20.0			10.0	10.0	10.0	10.0

Only two plans serve more than 1,000,000 persons. One of these is a community individual practice plan, Group Health Incorporated (GHI) of New York City. The other is a dental service corporation plan, California Dental Service, which at the end of 1968 had an enrollment of 1,252,000 persons. Four plans had an enrollment of 500,000 to 1,000,000. Three of these are community group practice plans—The Kaiser plans of Northern and Southern California and the Health Insurance Plan of Greater New York—and one is an employer-employee-union individual practice plan, the National Association of Letter Carriers Plan.

The distribution of the various types of plans by size is not greatly different. All have some quite small units among their ranks and most have a few relatively large units. The 23 community group practice plans contain 10 plans with an enrollment of less than 5,000. Most of these are rather atypical organizations and some of them fall in the ranks of group practice plans because they contract with a medical group for service, not having their own facility. Nine are of substantial size covering 25,000 persons or more.

The community individual practice plans range in size from several very small to very large organizations. This diversity in size is partly explained by the diverse nature of the programs in the group.

The employer-employee-union organizations, whether providing care through group practice or individual practice, are mainly quite small. Two-thirds have less than 5,000 enrollees and only 5 percent of the total cover more than 50,000 persons. Most of the private group clinic plans cover relatively small numbers of persons except for the one large plan.

The dental service corporation plans are quite diverse in size. Six have an enrollment under 5,000. They are, presumably, getting underway. Only four of the dental service corporations—the California, Washington, Hawaii, and Oregon plans—have as yet achieved any substantial enrollment.

More light on the size of these organizations is shed by table 4, which gives the distribution of enrollment by size of plan. It is evident that the large number of small plans have but a small portion of the total enrollment. The 60 percent of plans that serve under 5,000 persons have only 0.3 percent of the total enrollment. On the other hand, the 40 plans—8 percent of the total—that have over 50,000 enrollees contain over three quarters of the total enrollment of all plans. The two plans with over one million enrollees have 19 percent of the total enrollment. The next largest four plans, each serving one-half million to one million persons, have almost one quarter of the enrollment.

The three largest community group practice plans, the two Kaiser plans of California and HIP, contain 81 percent of the enrollment in all plans of this type. The largest community individual practice plan—GHI—contains 61 percent of the total enrollment of all such plans.

The two largest dental service corporations, California and Washington, have over 90 percent of the enrollment in all dental service corporation plans. The largest private group medical clinic has three quarters of the total enrollment in all plans of this type.

SERVICES COVERED

Table 5 shows the number of plans covering specified services and the number of persons covered for each service. Of the 482 plans, 74 percent cover hospital care. A slightly larger proportion —77 percent—cover surgical-obstetrical service. Sixty percent of the plans cover in-hospital medical visits; 65 percent cover X-ray and laboratory examinations outside the hospital; 57 percent, office and clinic visits; and 39 percent home visits. The relatively large number of plans covering X-ray and laboratory services out-of-hospital is explained by the fact that some plans cover surgery, in-hospital medical visits, and X-ray and laboratory examinations outside of the hospital, while others confine their self-insured program to physician service, including X-ray and laboratory examinations at the office or health center.

Dental care is covered by 21 percent of the plans. About a third of the plans provide or furnish out-of-hospital prescribed drugs, three quarters of them provide drugs on a prepayment basis, the remainder on some other basis. Virtually all of the latter are group practice plans that have one or more clinics or health centers and the usual practice is that the clinic pharmacy fills prescriptions at charges somewhat lower than those of commercial pharmacies. Some 12 percent of the plans cover visiting nurse service. A larger proportion, 22 percent, cover special duty nursing in the hospital with only one-half of these covering this service in the home.

Eye refraction examinations are covered by almost one-third of the plans. A slightly larger proportion reported that they provided eyeglasses under their program. Of these about three quarters stated that they covered eyeglasses on a prepayment basis; the remainder were group practice plans whose clinic had an optical unit which furnished eyeglasses on a charge basis. Eight percent of the plans covered nursing home care and 17 percent covered appliances.

In terms of enrollment, 7,300,000 persons—60 percent of the total enrolled for any benefit—were covered for hospital care. This

TABLE 4.—Enrollment, by size of plan

Type of plan	Total	Under 1,000	1,000–4,999	5,000–9,999	10,000–24,999	25,000–49,999	50,900–99,999	100,000–499,999	500,000–999,999	1,000,000 o more
	Enrollment (in thousands)									
All plans	12,203.5	65.5	343.1	421.3	879.3	1,121.4	1,280.5	2,884.7	2,845.9	2,361.8
Community group practice	2,883.5	.8	25.2	18.2	19.0	32.8	220.1	223.9	2,343.5	----------
Community individual practice	1,807.1	1.2	17.3	13.1	54.3	----------	122.0	489.8	----------	1,109.6
Employer-employee-union group practice	1,638.3	7.4	87.2	109.9	282.5	613.9	382.4	155.0	----------	----------
Union-employer welfare fund	1,044.4	.8	46.6	45.5	145.2	319.7	331.6	155.0	----------	----------
Employer or employer association	63.5	3.3	22.2	22.2	15.8	----------	----------	----------	----------	----------
Union	89.0	1.5	1.1	6.0	10.5	69.9	----------	----------	----------	----------
Employee association	243.3	----------	7.4	19.4	62.9	102.8	50.8	----------	----------	----------
Employer-employee association	198.1	1.8	9.9	16.8	48.1	121.5	----------	----------	----------	----------
Employer-employee-union individual practice	4,195.8	53.2	197.5	249.4	512.0	413.2	476.0	1,792.1	502.4	----------
Union-employer welfare fund	1,879.8	19.8	112.0	169.0	325.7	236.4	193.1	823.8	----------	----------
Employer or employer association	858.3	18.3	20.4	16.6	94.5	74.9	57.3	576.3	----------	----------
Union	1,116.0	1.0	3.8	2.8	----------	39.5	174.5	392.0	502.4	----------
Employee association	211.0	4.4	46.1	30.9	44.6	33.9	51.1	----------	----------	----------
Employer-employee association	130.7	9.7	15.2	30.1	47.2	28.5	----------	----------	----------	----------
Private group medical clinic	149.7	1.7	9.1	16.1	11.5	----------	----------	111.3	----------	----------
Private group dental clinic	42.8	----------	----------	14.8	----------	28.0	----------	----------	----------	----------
Dental service corporations	1,486.3	1.2	6.8	----------	----------	33.5	80.0	112.6	----------	1,252.2
	Percentage distribution									
All plans	100.0	.5	2.8	3.5	7.2	9.2	10.5	23.6	23.3	19.4
Community group practice	100.0	.1	.9	.6	.6	1.1	7.6	7.8	81.3	----------
Community individual practice	100.0	.1	.9	.7	3.0	----------	6.8	27.1	----------	61.4
Employer-employee-union group practice	100.0	.5	5.3	6.7	17.2	37.5	23.3	9.5	----------	----------
Union-employer welfare fund	100.0	.1	4.5	4.4	13.9	30.6	31.7	14.8	----------	----------
Employer or employer association	100.0	5.2	34.9	35.0	24.9	----------	----------	----------	----------	----------
Union	100.0	1.7	1.2	6.8	11.8	78.5	----------	----------	----------	----------
Employee association	100.0	----------	3.0	8.0	25.8	42.3	20.9	----------	----------	----------
Employer-employee association	100.0	.9	5.0	8.5	24.3	61.3	----------	----------	----------	----------

Employer-employee-union individual practice	100.0	1.3	4.7	6.0	12.2	9.8	11.3	42.7	12.0	
Union-employer welfare fund	100.0	1.0	6.0	9.0	17.3	12.6	10.3	43.8		
Employer or employee association	100.0	2.1	2.4	1.9	11.0	8.7	6.7	67.2		
Union	100.0	.1	.4	.3		3.5	15.6	35.1	45.0	
Employee association	100.0	2.1	21.8	14.6	21.2	16.1	24.2			
Employer-employee association	100.0	7.4	11.6	23.0	36.1	21.9				
Private group medical clinic	100.0	1.1	6.1	10.8	7.7			74.3		
Private group dental clinic	100.0			34.6		65.4				
Dental service corporations	100.0	.1	.4			2.3	5.4	7.6		84.2

TABLE 5.—Number of plans providing specified benefits and enrollment covered for each benefit, by enrollee age

[Enrollment in thousands]

Type of benefit	Plans		Enrollment		Enrollees by age		
	Number	Percent	Number	Percent of total	Under age 65	Aged 65 and over	
						Number	Percent of total
Any benefit	482	100.0	12,203.5	100.0			
Hospital care	357	74.1	7,276.7	59.6	6,774.6	502.1	6.9
Physician service:							
Surgical-obstetrical	372	77.2	8,751.7	71.7	8,278.9	472.6	5.4
In hospital medical visits	290	60.2	8,492.5	69.6	8,025.4	467.1	5.5
X-ray and laboratory outside hospital	312	64.7	9,228.5	75.6	8,711.7	516.8	5.6
Office and clinic visits	273	56.6	7,796.7	63.9	7,391.3	405.4	5.2
Home visits	189	39.2	6,591.1	54.0	6,268.1	323.0	4.9
Dental care	100	20.7	2,749.9	22.5	2,661.9	88.0	3.2
Drugs outside hospital	(1)	(1)	5,974.8	48.9	5,624.2	350.6	5.9
On prepayment basis	121	25.1	3,703.7	30.3	3,466.7	237.0	6.4
On other basis	42	8.7	2,271.1	18.6	2,157.5	113.6	5.0
Visting nurse service	59	12.2	5,267.3	43.2	5,040.8	226.5	4.3
Special duty nursing:							
Hospital	104	21.6	4,920.7	40.3	4,625.5	295.2	6.0
Home	51	10.6	3,444.8	28.2	3,320.8	124.0	3.6
Vision care:							
Refractions	153	31.7	5,057.1	41.4	4,758.7	298.4	5.9
Eyeglasses	(1)	(1)	3,673.7	30.1	3,537.1	136.6	3.7
On prepayment basis	131	27.2	1,200.8	9.8	1,178.0	22.8	1.9
On other basis	35	7.3	2,472.9	20.3	2,359.1	113.8	4.6
Nursing-home care	37	7.7	1,554.0	12.7	1,350.4	203.6	13.1
Appliances	81	16.8	2,907.6	23.8	2,709.9	197.7	6.8

[1] The number of plans are not additive because a plan might cover some of its enrollees on one basis, others on another.

coverage, it is apparent from the financial data provided by the plans, ranges from practically complete coverage of the hospital bill to benefits that would cover only a small part of the cost of a hospital confinement. In fact, as will be noted later, the benefits of a few of the plans are designed to supplement benefits under an insured program.

Seventy-two percent of the enrollees were covered for surgical-obstetrical benefits, 76 percent for X-ray and laboratory examinations outside of the hospital, and 64 percent for office and clinic visits. A smaller proportion were covered for physician home visits. This last is explained by the fact that some union welfare funds provide service only at a union health center and provide hospital, surgical and in-hospital visit benefits through insurance with Blue Cross-Blue Shield or an insurance company. Almost a quarter—23 percent of the total number of enrollees—were entitled to dental benefits. Some 30 percent were covered for drugs on a prepayment basis. Another 19 percent belong to plans which provided drugs on a charge basis. Some 43 percent of the enrollees

had some coverage of visiting nurse service and 40 percent some coverage of special duty nursing in the hospital, with about two-thirds of this number also covered for special duty nursing in the home.

Eye examination for eyeglasses was covered for 41 percent of the total number of enrollees. Some 30 percent of all enrollees belonged to plans that provided eyeglasses on either a prepayment basis—a third of these enrollees—or a charge basis. Mainly, the latter plans were group practice units whose clinics had an optical unit which filled prescriptions for eyeglasses at prices somewhat below those of outside optical establishments. Thirteen percent of the enrollees were covered for nursing home care and almost a quarter for appliances.,

Compared with Blue Cross, Blue Shield and insurance companies[3] it is apparent that these plans are stressing coverage of services other than hospital care, surgery and in-hospital visits in much greater degree. This is due to a variety of factors. One is that some of these plans provide only dental benefits. Another explanation is that the aim of the community group practice plans is to provide a comprehensive health service. Another factor is that many employer-employee-union programs have purchased insurance coverage of hospital care, surgery and physician in-hospital visits, but provide physician office and home visits, or dental care, or drugs, or optical benefits, or some combination of them through self-insurance. It is apparent that many of these plans are innovators, providing types of coverage not generally or widely covered by Blue Cross-Blue Shield or insurance companies.

ENROLLMENT OF PERSONS UNDER AND OVER AGE 65

Table 5 also provides data on enrollment of persons under and over age 65. Since almost all of the aged have coverage of hospital care, physician service, and various other services under the Federal Government's Medicare program, they have less need for private health insurance than the rest of the population. So in presenting data on the extent of private health insurance coverage of the population, separate figures for persons under and over age 65 are desirable.

The data are estimates since plans with about 15 percent of the enrollment (the proportion varied by service) did not know the age breakdown of their enrollees and it was assumed that the age distribution of the enrollees of the plans that did not have such data was the same as for the plans that did. Of the persons

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[3] See Louis S. Reed, "Private Health Insurance, 1968: Enrollment, Coverage, and Financial Experience," *Social Security Bulletin*, December 1969.

covered for hospital care, 93 percent, it is estimated, were under age 65 and 7 percent were over age 65. The proportion of the enrollees aged 65 and over was a little less for most of the other services, except that 13 percent of the enrollees in plans that covered nursing home care were over 65. This may be due to the fact that both the United Mine Workers Welfare and Retirement Fund and some of the railroad hospital associations cover this service and both have a relatively high proportion of aged enrollees. The proportion of persons aged 65 and over among those covered for dental care is low, only 3 percent. But the figures may not be reliable since only a small proportion of the enrollees for dental care benefits were in plans that knew the distribution of enrollees by age.

BENEFITS PROVIDED BY THE VARIOUS TYPES OF PLANS

Table 6 shows the number of plans of each type that provide specified benefits. Of the 23 community group practice plans, 18 provide hospital care. The only plans of any size that do not

TABLE 6.—Number of plans of each type providing specified benefits

Type of benefit	All plans	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Private group medical clinic	Dental care plans [1]
	Number of plans						
Any benefit [2]	482	23	17	101	317	11	13
Hospital care	357	18	12	74	247	6	----
Physician service:							
Surgical-obstetrical	372	21	8	81	253	9	----
In-hospital medical visits	290	21	8	62	190	9	----
X-ray and laboratory outside hospital	312	22	9	84	186	11	----
Office and clinic visits	273	23	9	89	143	9	----
Home visits	189	17	6	45	113	8	----
Dental care	100	----	3	32	52	----	13
Drugs outside hospital	(3)	(3)	(3)	(3)	(3)	(3)	----
On prepayment basis	121	14	3	41	61	2	----
On other basis	42	7	2	17	14	2	----
Visiting nurse service	59	11	2	10	35	1	----
Special duty nursing:							
Hospital	104	9	4	15	74	2	----
Home	51	4	2	2	42	1	----
Vision care:							
Refractions	153	15	1	52	74	5	----
Eyeglasses	(3)	(3)	(3)	(3)	(3)	1	----
On prepayment basis	131	2	----	30	99	----	----
On other basis	35	8	----	12	14	1	----
Nursing-home care	37	6	1	5	25	----	----
Appliances	81	5	3	15	57	1	----
Other services	15	1	1	1	32	----	----

TABLE 6.—Number of plans of each type providing specified benefits—Continued

Type of benefit	All plans	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Private group medical clinic	Dental care plans [1]
	Percentage distribution						
Any benefit [2]	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	74.1	78.3	70.6	73.3	77.9	54.5	----
Physician service:							
Surgical-obstetrical	77.2	91.3	47.1	80.2	79.8	81.8	----
In-hospital medical visits	60.2	91.3	47.1	61.4	59.9	81.8	----
X-ray and laboratory outside hospital	64.7	95.6	52.9	83.2	58.7	100.0	----
Office and clinic visits	56.6	100.0	52.9	88.1	45.1	81.8	----
Home visits	39.2	73.9	35.3	44.5	35.6	72.7	----
Dental care	20.7	----	17.6	31.7	16.4	----	100.0
Drugs outside hospital	(3)	(3)	(3)	(3)	(3)	(3)	----
On prepayment basis	25.1	60.9	17.6	40.6	19.3	18.2	----
On other basis	8.7	30.4	11.8	16.8	4.4	18.2	----
Visiting nurse service	12.2	47.8	11.8	9.9	11.0	9.1	----
Special duty nursing:							
Hospital	21.6	39.1	23.5	14.8	23.3	18.2	----
Home	10.6	17.4	11.8	2.0	13.2	9.1	----
Vision care:							
Refractions	31.7	65.2	5.9	57.4	23.3	45.4	----
Eyeglasses	(3)	(3)	----	(3)	(3)	9.1	----
On prepayment basis	27.2	8.7	----	29.7	31.2	----	----
On other basis	7.3	34.8	----	11.9	4.4	9.1	----
Nursing-home care	7.7	26.1	5.9	4.9	7.9	----	----
Appliances	16.8	21.7	17.6	14.8	24.3	9.1	----
Other services	3.1	4.3	5.9	1.0	10.1	----	----

[1] Includes three private group dental clinics and 10 dental service corporation plans.
[2] Data do not add to totals since most plans provide more than one benefit.
[3] Figures not additive because a plan might cover some of its enrollees on one basis, others on another basis.

provide this benefit are the Health Insurance Plan of Greater New York (which requires its subscribers to have the coverage through Blue Cross, an insurance company, or other appropriate arrangements) and Group Health Association of Washington, D.C. The latter organization covers hospital care, but uses the local Blue Cross plan to pay hospitals; in order to avoid double counting in national figures for the various types of health insurance organizations, GHA is shown as not providing hospital care.[4]

All of the community group practice plans of any size provide comprehensive medical service, i.e., all five physician services. None provide dental care. All except two provide drugs outside the hospital; two-thirds do so on a prepayment basis, at least for some

[4] This solution of this problem may not be the best possible; GHA does underwrite hospital care. The problem is noted for future attention.

subscribers, the other third on a charge basis. About half provide visiting nurse service and a little less than half special duty nursing in the hospital. Most—all of the significant ones—cover eye refraction examinations; two-thirds of those that cover eye refractions have arrangements for furnishing eyeglasses—generally on a charge basis.

Of the 17 community individual practice plans, 12 provide hospital care, and nine provide some physician service. Three provide dental care and the same number provide prepayment coverage of drugs.

Of the employer-employee-union group and individual practice plans, about three-quarters, in both cases, cover hospital care. About four-fifths of both groups of plans cover surgical care. However, a considerably larger proportion of the group practice than of the individual practice plans cover X-ray and laboratory examinations and physician office and clinic visits. Almost a third of the employer-employee-union group practice plans cover dental care—about twice as many proportionately as the employer-employee-union individual practice plans. Almost three-fifths of the employer-employee-union group practice plans cover eye refraction examinations; a majority of these had arrangements for furnishing eyeglasses—mainly on a prepayment basis. Of the employer-employee-union individual practice plans, almost a third had prepayment arrangements for covering part or all of the cost of eyeglasses.

Of the 11 private group medical clinics, only six covered hospital care. Ross-Loos, the largest, covers hospital care under its subscriber contracts, but since it insures this benefit through an insurance company it is entered as not providing hospital care. All of these plans cover physician X-ray and laboratory examinations and all except two cover physician office and clinic visits. (The explanation of this apparent anomaly is that two plans cover only surgery, in-hospital visits and X-ray and laboratory examinations and two cover X-ray and laboratory examinations and office visits, but not surgery and care in the hospital.) Two of the 11 cover drugs on a prepayment basis, two cover special duty nursing, and five cover eye refraction examinations.

The 13 dental plans, i.e., the 10 dental service corporations and the three private group dental clinic plans, of course, cover only dental care.

The enrollment figures given in table 7 provide a more significant picture of the coverages provided by the different types of plans. Of the 2,900,000 persons enrolled in the community group practice plans, almost three quarters are covered for hospital care and virtually all are covered for all five physician services. Al-

TABLE 7.—Enrollment covered for specified benefits, by type of plan

Type of benefit	All plans	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Private group medical clinic	Dental care plans [1]
	Enrollment						
Any benefit	12,204	2,884	1,807	1,638	4,196	150	1,529
Hospital care	7,277	2,103	404	920	3,829	20	----
Physician service:							
Surgical-obstetrical	8,752	2,874	1,258	1,034	3,442	143	----
In-hospital medical visits	8,492	2,873	1,260	714	3,503	143	----
X-ray and laboratory outside hospital	9,229	2,880	1,197	1,430	3,577	144	----
Office and clinic visits	7,797	2,884	1,130	1,375	2,264	145	----
Home visits	6,591	2,857	1,072	484	2,035	143	----
Dental care	2,750	----	304	475	442	----	1,529
Drugs outside hospital	5,975	2,383	422	995	2,062	114	----
On prepayment basis	3,704	949	415	431	1,907	2	----
On other basis	2,271	1,434	7	564	155	112	----
Visiting nurse service	5,267	2,818	1,110	192	1,142	6	----
Special duty nursing:							
Hospital	4,921	2,234	503	300	1,876	8	----
Home	3,445	1,835	433	24	1,147	6	----
Vision care:							
Refractions	5,057	2,852	1	1,226	843	136	----
Eyeglasses	3,674	2,117	----	750	695	111	----
On prepayment basis	1,201	5	----	531	665	----	----
On other basis	2,473	2,112	----	219	31	111	----
Nursing-home care	1,554	166	----	59	1,329	----	----
Appliances	2,908	415	433	299	1,748	12	----
Other services	641	2	(2)	19	620	----	----
	Percentage distribution						
Any benefit	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	59.6	72.9	22.4	56.2	91.3	13.2	----
Physician service:							
Surgical-obstetrical	71.7	99.7	69.6	63.1	82.0	95.2	----
In-hospital medical visits	69.6	99.4	69.7	43.6	83.5	95.2	----
X-ray and laboratory outside hospital	75.6	99.9	66.2	87.3	85.2	96.3	----
Office and clinic visits	63.8	100.0	62.5	83.9	54.0	96.5	----
Home visits	54.0	99.1	59.3	29.6	48.5	95.5	----
Dental care	22.5	----	16.8	29.0	10.5	----	100.0
Drugs outside hospital	48.9	82.6	23.3	60.7	49.1	76.0	----
On prepayment basis	30.3	32.9	22.9	26.3	45.4	1.3	----
On other basis	18.6	49.7	.4	34.4	3.7	74.7	----
Visiting nurse service	43.2	97.7	61.4	11.7	27.2	3.7	----
Special duty nursing:							
Hospital	40.3	77.5	72.8	18.3	44.7	5.3	----
Home	28.2	63.6	23.9	1.5	27.3	4.0	----
Vision care:							
Refractions	41.4	98.9	(2)	74.8	20.1	90.7	----
Eyeglasses	30.1	73.4	----	45.8	16.5	74.0	----
On prepayment basis	9.8	0.2	----	32.4	15.8	----	----
On other basis	20.3	73.2	----	13.4	.7	74.0	----
Nursing home care	12.7	5.8	(2)	3.6	31.7	----	----
Appliances	23.8	14.4	24.0	18.3	41.7	8.0	----
Other services	5.2	.1	(2)	1.1	14.8	----	----

[1] Includes three private group dental clinics and 10 dental service corporation plans.
[2] Less than 0.05.

though 80 percent of the enrollees are in plans that provide drugs on one basis or another, only a third of these are in plans that have prepayment coverage of drugs. Almost all of the enrollees are covered for visiting nurse service; over three-fourths for special duty nursing care in the hospital. Almost all are covered for eye refraction examinations, but virtually none for eyeglasses on a prepayment basis (most of the larger plans have optical units which furnish eyeglasses on a charge basis). Six percent are covered for nursing home care.

Of the 1,800,000 persons enrolled in the community individual practice plans, only about 400,000 are covered for hospital care; some 1,200,000 are covered for physician services. These figures mainly reflect the enrollment of Group Health Insurance, Incorporated of New York City, which does not cover hospital care (at least to any extent). Some 300,000 are covered for dental care; almost all are enrollees of Group Health Dental Insurance, New York City. Approximately 23 percent are covered for drugs on a prepayment basis and 28 percent for special duty nursing.

Of those enrolled in the employer-employee-union group practice plans, a little more than half are covered for hospital care and some 60 percent for surgery. The proportion goes up to 87 and 84 percent, respectively, for X-ray and laboratory examinations and office or clinic visits. The explanation of the high percentages covered for the latter two services is the substantial number of employer-employee-union plans that maintain health centers that provide only medical and/or dental service only at the center. Almost 30 percent of all the enrollees of these plans are covered for dental care and about a third are covered for drugs on a prepayment basis.

Among the 4,200,000 persons covered by the employer-employee-union individual practice plans, 91 percent are covered for hospital care and more than four-fifths are covered for surgery, in-hospital visits, and X-ray and laboratory examinations, but the proportion covered for office visits drops to 54 percent. Eleven percent are covered for dental care, 45 percent for drugs on a prepayment basis and 16 percent for eyeglasses on a prepayment basis.

Of the enrollees of private group medical clinics only a small percentage—13 percent—are covered for hospital care;[5] over 95 percent are covered for all five physician services; none are covered for dental care and practically none for drugs on a prepayment basis. Almost all are covered for eye refraction examinations, but none are covered for eyeglasses on a prepayment basis.

[5] Few of these clinics have their own hospital and they prefer not to underwrite a service that they do not offer. Covered groups have hospital care insurance through Blue Cross or an insurance company.

More insight into the varieties of coverage provided by these plans is given in table 8. Of the 482 plans, 433 provide more than one type of benefit; these plans have 82 percent of the total enrollment. Conversely 49 plans, about 10 percent of the total with 18 percent of total enrollment, provide one benefit only. Of these 49 plans, 12 provide hospital care only. Half of them are community individual practice plans; the other half are employer-employee-union individual practice plans. Nineteen plans with 1,900,000 enrollees provide dental care only. Besides the 10 dental service corporations and the three private group medical clinics, one is a community individual practice plan and five are employer-employee-union programs.

Fifteen plans with an enrollment of 26,000 persons provide vision care only. All are the employer-employee-union individual practice plans; they provide allowances against charges incurred for eye examination and glasses.

As regards the coverage of physician service, 63 plans, with 19 percent of the total enrollment, do not cover physician service at all. Some 419 plans provide some coverage. Of these, 165 with 57 percent of the total enrollment cover all five physician services. The remainder cover only certain services—46 surgery (with or without obstetrics) only; 53, with over a million enrollment, cover surgery, in-hospital visits, and laboratory and X-ray examinations; 21 cover office and clinic visits with or without X-ray and laboratory examinations, only.

Of the 165 plans—they have an enrollment of 6,948,000—that cover all five physician services, some 36 with over 5 million enrollees also cover nursing and drugs with or without other benefits. (All enrollees have hospital coverage but not necessarily directly by this plan.) Not all of these enrollees may be covered for, say, drugs, since plans are included in this tabulation on the basis of benefits provided to any of their subscribers. Only a few of the plans that cover all five physician services cover only these services. The great majority provide all five physician services (with or without hospital care) and various other benefits.

It may be noted at this point that some plans provide certain benefits designed to be of a supplementary character. For example, certain hospital benefits may be provided which by themselves are meager in scope, but are designed to supplement, amplify or extend hospital benefits provided through insurance with a carrier. More often, both hospital and medical benefits were supplemental. Supplemental benefits of this type were offered by at least 16 plans with an enrollment of 37,000. Most of these were employer-employee-union individual practice plans.

TABLE 8.—Plans and enrollment, by pattern of benefits

[Enrollment in thousands]

Pattern of benefits	Plans		Enrollment		Community group practice		Community individual practice		Employer-employee union group practice		Employer-employee union individual practice		Private group medical clinic		Dental plans [1]	
	Number	Percent	Number	Percent	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment
Any benefit	482	100.0	12,203.5	100.0	23	2,883.5	17	1,807.1	101	1,638.3	317	4,195.8	11	149.7	13	1,529.1
Comprehensive physician service and other benefits:																
Plans providing all 5 physician services	165	34.2	6,947.7	56.9	16	2,865.1	3	1,185.5	39	544.6	100	2,215.3	7	137.2	----	----
All 5 physician services only	6	1.2	39.0	.3	2	24.5	1	5.9	----	----	2	3.5	1	5.1	----	----
All 5 physician services and hospitalization only	17	3.5	186.5	1.5	1	7.5	----	----	2	7.4	13	171.4	1	.2	----	----
All 5 physician services (with or without hospitalization) and nursing only	12	2.5	324.0	2.7	1	76.7	1	70.0	3	158.3	6	17.0	1	2.0	----	----
All 5 physician services (with or without hospitalization) and drugs only	14	2.9	55.2	.5	1	1.9	----	----	8	16.3	5	37.0	----	----	----	----
All 5 physician services (with or without hospitalization) and nursing and drugs, with or without other benefits	36	7.5	5,030.9	41.2	8	1,712.8	1	2,109.6	4	66.8	22	1,130.2	1	11.5	----	----
All other combinations	80	16.6	1,312.1	10.7	3	41.7	----	----	22	295.8	52	856.2	3	118.4	----	----
Physician service:																
Plans providing 1 or more physician services	419	86.9	9,908.0	81.2	23	2,883.5	10	1,264.1	96	1,570.4	279	4,040.4	11	149.7	----	----
Surgery with or without obstetrics only	46	9.5	218.0	1.8	----	----	----	----	4	39.2	42	178.8	----	----	----	----
Surgical and in-hospital medical only	27	5.6	43.6	.4	----	----	----	----	1	1.1	26	42.5	----	----	----	----
Surgical, in-hospital medical and X-ray and lab. only	53	11.0	1,118.9	9.2	----	----	1	19.4	3	149.8	47	944.5	2	5.3	----	----
Office, clinic visits with or without X-ray and lab	21	4.4	458.7	3.7	1	3.0	----	----	10	368.5	8	80.0	2	7.2	----	----
All 5 physician services	165	34.2	6,947.7	56.9	15	2,859.6	4	1,186.3	39	544.6	100	2,220.0	7	137.2	----	----
All other combinations	107	22.2	1,121.1	9.2	7	20.9	5	58.4	39	467.2	56	574.6	----	----	----	----

One benefit only:														
Plans providing one benefit only	49	10.2	2,172.8	17.8	----------	7	543.1	2	42.4	27	58.3	----------	13	1,529.1
Hospital care only	12	2.5	270.4	2.2	----------	6	260.7	----------		6	9.8	----------		
Physician office and clinic visits only	1	.2	3.0	(2)	----------					1	3.0	----------		
Dental care only	19	4.0	1,869.5	15.3	----------	1	282.4	2	42.4	3	15.6	----------	13	1,529.1
Drugs only	1	.2	.3	(2)	----------					1	.3	----------		
Vision care only	15	3.1	26.4	.2	----------					15	26.4	----------		
Other benefit only	1	.2	3.2	(2)	----------					1	3.2	----------		

[1] Includes three private group clinic plans nd 10 dental service corporation plans.
[2] Less than 0.05.

TABLE 9.—Arrangements for provision of medical and dental services

[Enrollment in thousands]

Arrangements mainly used	Plans		Enrollment		Community group practice [1]		Community individual practice		Employer-employee-union group practice [1]	
	Number	Percent	Number	Percent	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment
Plans providing medical service mainly	450	100.0	10,072.8	100.0	23	2,883.5	12	1,275.4	[2] 96	1,543.6
Through individual practice	320	71.1	5,496.0	54.6	----	----	12	1,275.4	----	----
Through group practice	130	28.9	4,476.8	45.4	23	----	----	----	96	1,543.6
By own clinic or center and its medical staff	93	20.7	1,846.6	18.3	13	238.8	----	----	69	1,458.1
By contract with one or more medical groups	37	8.2	2,730.2	27.1	10	2,644.7	----	----	27	85.5
Plans providing dental service	100	100.0	3,033.1	100.0	----	----	3	303.7	33	571.2
Through individual practice	64	64.0	2,419.1	79.8	----	----	3	303.7	----	----
Through group practice	36	36.0	614.0	20.2	----	----	----	----	----	----
By own dental clinic and its staff	26	26.0	573.2	18.9	----	----	----	----	23	530.4
By contract with one or more dental groups	10	10.0	40.8	1.3	----	----	----	----	10	40.8

[1] Data for other types of plans are not shown because there is no need. The individual practice plans provide service through individual practice. The 11 private group medical clinic plans and the three private group dental clinic plans provide service through their own clinic and staff.

[2] Does not agree precisely with number and enrollment of plans providing medical service as shown earlier because plans were classified as group practice if they provided either medical service or dental care through group practice.

Not one of these 482 plans by itself provides a comprehensive health service, if by that one means hospital care, physician service in the office, home and hospital, dental care, drugs, home health services (visiting nurse, nursing care and other services in the home), appliances and nursing home care, and other essential health services. Those that come nearest to it are the community group practice plans which provide complete or nearly complete hospital care (at least for general illness) complete physician service, some coverage of drugs at least for some of their enrollees, and some coverage of visiting nurse service and special duty nursing in the hospital. Few of the employer-employee-union programs provide benefits that comprehensive.

ARRANGEMENTS FOR PROVISION OF MEDICAL AND DENTAL SERVICES

Table 9 provides more information on the arrangements through which the plans provide medical service and dental service. Of the 450 plans that provided medical (i.e., physician service) 320 with an enrollment of 5,500,000, provided such benefits mainly through individual practice, i.e., by fee or indemnity payments to private practitioners or reimbursement of covered persons for expenses incurred.[6] The other 130, with an enrollment of 4,600,000, provided benefits mainly through arrangements that were classified as group practice. Ninety-three of these, serving 1,800,000 persons, provided service through their own medical clinic or health center and salaried medical staff;[7] 37 plans, with an enrollment of 2,700,000 persons, provided care by contract with one or more medical groups.

Among the larger community group practice plans, the plans that provide service through their own facilities and salaried personnel are Group Health Cooperative of Puget Sound, Group Health Association (Washington, D.C.) and Community Health Association (Detroit).[8] Among the larger plans that provide service through contract with one or more medical groups are the Kaiser Health Plans of California, Oregon, Hawaii and Cleveland, Ohio, and the Health Insurance Plan of Greater New York (HIP).

HIP provides service to its subscribers through 31 autonomous medical groups with which it contracts for service. Almost all of these groups are organized as partnerships of physicians. The

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[6] The questionnaire asked the plan to indicate the arrangement through which medical-dental services were mainly provided.

[7] Including partners in private medical group clinics. These plans include the private medical group clinics, many or most of whose staffs are partners and hence not completely on a salaried basis.

[8] This information concerning the named plans can be provided, although based in part on questionnaire responses, since these plans are nonprofit and provide this information in their published reports.

plan pays each group on the basis of a specified amount per person per year (negotiated periodically between the plan and the groups) for each enrollee who has elected to receive service from the particular group and for whom the group assumes responsibility. With one or two exceptions, the groups own their facilities. Many groups serve private patients on a fee for service basis.

The arrangements under the Kaiser plans are of a different nature. Here each plan contracts with a single group of physicians organized as a partnership or incorporated association. The group of physicians is paid a stipulated amount per subscriber per year —the amount being negotiated annually. In general the plan, rather than the group of physicians, owns the facilities and the group of physicians has no outside private (fee-for-service) practice. The fact that all services are provided by the one group of physicians, which is wholly dependent upon the plan for all its income, makes the relationship between the group of physicians and the plan much closer and more interdependent than in the case of HIP. While the remuneration of the group as a whole is fixed by negotiation with the plan, the group itself determines the remuneration of each of its members.

Of the 23 community group practice plans, 13 with an enrollment of 239,000, provide service through the plan's own clinic and medical staff while 10 plans, with 2,645,000 enrollees, provide service through contract with one or more medical groups.

The situation is different with the employer-employee-union group practice plans. Of the 96 such plans, with an enrollment of 1,540,000, that provide medical service, 69, with more than 90 percent of the total enrollment, provide care through their own centers and salaried medical staffs—the overwhelming majority of the physicians are part-time—while 27 plans, with an enrollment of 86,000, provide care by contract with one or more medical groups. It is possible that in some of these cases the contracting medical group was, in effect, carrying the risk and that it, classified as a private medical group clinic, should have been classified as the plan rather than the welfare fund or other employer-employee organization. In some cases it was difficult from the information provided to determine the precise nature of the arrangement.

Of the 11 private group medical clinics, all provide service through their own clinics and their own salaried or partnership staff.

Of the 100 plans providing dental service 64, with 80 percent of the total enrollment, provide service wholly or mainly through individual practice while 36 provide service through group practice. Three of these are the private group dental clinics that, of

course, provide service through their own staffs. Of the 33 employer-employee-union group practice plans that provide dental service through group practice to 570,000 persons, 23 with over 90 percent of the covered persons, provide service through their own dental clinics and salaried staffs, while 10 do so by contract with one or more dental groups. Again, it was difficult in some instances to tell from the questionnaire response whether it was the employer-employee-union organization or the private group dental clinic that was carrying the risk and was, therefore, the plan.

If a private dental clinic provided whatever dental service (of specified nature) was required by a group of employees or union members for a specified amount per member per year, the clinic was assumed to be carrying the risk and the plan was classified as a private group dental clinic plan. If the arrangement was such that all union members would obtain covered dental services from the dental group in question and the welfare fund would pay the dental group specified fees for each unit of service performed, then it was assumed that the welfare fund carried the risk and not the dental group.,

III. PERSONNEL AND FACILITIES

IT IS NOT MERELY the group practice plans that own facilities and employ personnel or, alternatively, contract with medical or dental groups. A few of the plans that provide service mainly through individual practice also provide some service through group practice arrangements and own facilities and employ personnel.

Of the 482 plans, more than a quarter—130—own one or more facilities (see table 10). These plans have an enrollment of more than 4,000,000. Of these 130 plans, 19 are community group practice plans, two are community individual practice plans (these are hospitals that have their own prepayment plans), 80 are employer-employee-union group practice plans, 15 are employer-employee-union individual practice plans, 11 are private group medical clinics and three are private group dental clinics. Twenty-six plans, with an enrollment of 2,200,000, own one or more hospitals. Eight of these are community group practice plans and three are private group medical clinics. Some 110 plans, with an enrollment of 3,800,000, own, i.e., operate clinics or health centers. Most of the community group practice plans own one or more clinics or health centers; the remainder contract with medical or dental groups that have facilities. Seventy-three employer-employee-union group practice plans have centers or clinics. All of the private group medical clinics, of course, have their own centers.

Thirty-four plans, with an enrollment of 870,000, have dental clinics. Three of these plans are private group dental clinics, 27 are employer-employee-union group practice plans, and three are employer-employee-union individual practice plans. Some 69 plans, with an enrollment of 3,200,000, have a pharmacy (one or more) and 38, with an enrollment of 2,800,000, have an optical unit.

All of the Kaiser plans, with the exception of the newly taken over Cleveland plan, have their own hospital or hospitals—more than 12 in all.[1] Community Health Association (of Detroit) to all intents and purposes has its own hospital.[2] HIP did not have a

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[1] It is reported that the main reason the former Community Health Foundation Plan of Cleveland desired to join the Kaiser system of Health Plans was so that a hospital could be acquired; the plan itself did not have the funds for purchase or construction of a hospital.

[2] The hospital is owned by a separate corporation but both organizations are controlled by the same persons.

TABLE 10.—Plans owning facilities

[Enrollment in thousands]

Type of plans	All plans		Plans owning one or more facilities		Type of facility owned									
					Hospital		Clinic or health center		Dental clinic		Pharmacy		Optical unit	
	Number	Enrollment	Number	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment
All plans	482	12,203.5	130	4,210.5	26	2,192.1	110	3,827.1	34	872.5	69	3,228.6	38	2,809.0
Community group practice	23	2,883.5	19	2,108.7	8	1,954.4	18	2,106.8	1	70.5	16	2,099.4	9	2,044.7
Community individual practice	17	1,807.1	2	6.7	1	4.8					1	1.9		
Employer-employee-union group practice	101	1,638.3	80	1,581.5	13	197.1	73	1,498.4	27	625.5	43	945.8	23	623.1
Union-employer welfare fund	45	1,044.4	38	1,007.7			33	932.3	18	356.0	14	564.5	10	311.1
Employer or employer association	21	63.5	14	53.0	3	29.5	14	53.0			12	43.9	2	7.2
Union	7	89.0	5	87.3	1	.9	5	87.3	1	31.6	2	37.6	4	86.4
Employee association	13	243.3	12	239.9	6	143.2	11	233.3	4	132.6	10	214.2	5	159.6
Employer-employee assn	15	198.1	11	193.6	3	23.5	10	192.5	4	105.3	5	85.6	2	58.8
Employer-employee-union individual practice	317	4,195.8	15	321.1	1	28.5	8	72.2	3	133.7	6	166.1	1	4.3
Union-employer welfare fund	149	1,879.8	7	160.6			3	15.7	2	123.7	1	17.1	1	4.3
Employer or employer association	70	858.3	1	10.1					1	10.0				
Union	11	1,116.0	1	87.5							1	87.5		
Employee association	43	211.0	3	33.1			2	26.7			3	33.1		
Employer-employee association	44	130.7	3	29.8	1	28.5	3	29.8			1	28.4		
Private group medical clinic	11	149.7	11	149.7	3	7.3	11	149.7			3	15.4	5	136.9
Private group dental clinic	3	42.8	3	42.8					3	42.8				
Dental service corporations	10	1,486.3												

hospital at the time of the survey, but has long felt that some of its medical groups were handicapped by not having their own hospital and it has recently acquired one.

The majority of the employer-employee-union group practice plans that have hospitals are the railway hospital associations. These are organized either as employee benefit associations or employer-employee benefit associations. One railway hospital association plan has its own hospital but provides medical service mainly through individual practice arrangements.

The data on plans owning clinics or health centers must be interpreted in the light of the fact that some group practice plans do not directly provide service but contract with medical groups that have their own facliities, e.g., the Health Insurance Plan of Greater New York. All of the Kaiser plans are shown as owning facilities, although they do not directly employ the physicians that use these facilities.

Table 11 shows the plans that employ specified types of professional personnel, full or part-time. In all, 112 plans, with an enrollment of slightly over 4,000,000, employ one or more types of professional personnel. Some 90 plans, with an enrollment of almost 2,000,000, employ physicians. Thirteen of these plans are community group practice plans, but they are the smaller ones and serve only some 240,000 persons. The larger community group practice plans—the Kaiser plans and HIP—do not directly employ physicians but contract with physician groups. The majority of the plans that employ physicians are employer-employee-union group practice plans. As will be shown, almost 90 percent of the physicians so employed are on a part-time basis.

The 11 private group medical clinic plans are shown as employing physicians. However many, perhaps most, of the physicians who constitute the staffs of these clinics are technically not salaried employees, but partners.[3] The same is true as regards the three private group dental clinics.

Thirty-four plans, with an enrollment of almost a million, employ dentists. Aside from the three dental clinics, the rest, with one exception, are employer-employee-union organizations and two-thirds of the dentists they employ are part-time. Fifty-seven plans employ one or more pharmacists, 31 employ one or more optometrists.

Table 12 provides more information on the personnel employed by the plans. The 112 plans that employ any full or part-time personnel employ a total of 5,290 professional persons of whom

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[3] Presumably they receive a fixed stipend each month and then a share of the distributed profit at the end of the year.

TABLE 11.—Plans employing specified types of professional personnel

[Enrollment in thousands]

Type of plan	Total		Type of personnel (full or part-time)							
	Plans	Enrollment	Physicians		Dentists		Pharmacists		Optometrists	
			Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment
All plans	112	4,040.3	90	1,801.4	34	955.2	57	3,157.8	31	2,815.8
Community group practice	19	2,108.7	13	238.8	1	70.5	15	2,080.3	9	2,044.7
Community individual practice	1	2.0	----	----	----	----	1	2.0	----	----
Employer-employee-union group practice	63	1,356.5	59	1,281.1	25	616.9	32	894.0	17	641.4
Union-employer welfare fund	24	792.5	19	717.1	17	353.5	11	513.4	8	352.0
Employer-employer association	12	49.3	12	49.3	----	----	6	35.8	1	7.0
Union	5	87.3	5	87.3	1	31.6	2	37 6	3	80.4
Employee association	11	233.9	11	233.9	3	126.5	8	201.6	4	153.5
Employer-employee association	11	193.5	11	193.5	4	105.3	5	105.6	1	48.5
Employer-employee-union individual practice	15	380.6	7	131.8	5	225.0	6	166.1	1	4.3
Union-employer welfare fund	7	220.2	3	75.2	3	191.7	1	17.1	1	4.3
Employer or employer association	1	10.0	----	----	1	10.1	----	----	----	----
Union	1	87.5	----	----	----	----	1	87.5	----	----
Employee association	3	33.0	2	26.7	1	23.2	3	33.0	----	----
Employer-employee association	3	29.9	3	29.9	----	----	1	28.5	----	----
Private group medical clinic	11	149.7	11	149.7	----	----	3	15.4	4	125.4
Private group dental clinic	3	42.8	----	----	3	42.8	----	----	----	----
Dental service corporation	----	----	----	----	----	----	----	----	----	----

TABLE 12.—Plans employing professional personnel and number of professionals employed

Type of personnel	All plans		Community group practice		Community individual practice		Employer-employee union group practice		Employer-employee union individual practice		Private group medical clinic		Private group dental clinic	
	Plans employing personnel	Personnel employed	Plans employing personnel	Personnel employed	Plans employing personnel	Personnel employed	Plans employing personnel	Personnel employed	Plans employing personnel	Personnel employed	Plans employing personnel	Personnel employed [1]	Plans employing personnel	Personnel employed [1]
Personnel														
Total	[2]	5,290	[2]	577	1	1	[2]	3,174	[2]	1,040	[2]	439	3	59
Physicians	90	4,398	13	318	----	----	59	2,726	7	934	11	420	----	----
Dentists	34	450	1	15	----	----	25	293	5	83	----	----	3	59
Pharmacists	57	261	15	146	1	1	32	85	6	22	3	7	----	----
Optometrists	31	181	9	98	----	----	17	70	1	1	4	12	----	----
Full-time personnel														
Total	[3]	1,344	[3]	436	1	1	[3]	477	[3]	78	11	329	3	23
Physicians	71	867	11	214	----	----	42	306	7	34	11	313	----	----
Dentists	19	146	1	9	----	----	12	93	3	21	----	----	3	23
Pharmacists	49	220	13	122	1	1	26	69	6	22	3	6	----	----
Optometrists	17	111	7	91	----	----	7	9	1	1	2	10	----	----
Part-time personnel														
Total	[3]	3,946	[3]	141	----	----	[3]	2,697	[3]	962	[3]	110	3	36
Physicians	63	3,531	8	104	----	----	43	2,420	6	900	6	107	----	----
Dentists	27	304	1	6	----	----	20	200	3	62	----	----	3	36
Pharmacists	18	41	8	24	----	----	9	16	----	----	1	1	----	----
Optometrists	20	70	6	7	----	----	12	61	----	----	2	2	----	----

[1] Includes partners.
[2] Does not add since figure represents the number of different plans employing at least one type of professional personnel.
[3] Not shown since some plans employ both full and part-time personnel.

1,344 are full-time and 3,946 are part-time. Of the total number employed, 4,398 are physicians, 450 are dentists, 261 are pharmacists and 181 are optometrists. Again it must be borne in mind that these data, in a sense, are incomplete since they do not take account of the personnel in medical or dental groups with which plans contract for service.

Of the total full or part-time professional personnel employed, about a tenth are employed by the community group practice plans, three-fifths are employed by employer-employee-union group practice plans, about a fifth by employer-employee-union individual practice plans and the remainder by private group medical or dental clinics.

Of the 867 physicians employed full-time, 214 are employed by 11 community group practice plans, 306 by employer-employee-union group practice plans, 34 by employer-employee-union individual practice plans, and 313 by the private group medical clinics. In the latter case, the physicians enumerated constitute the entire full-time medical staff of these clinics, but it should be understood that in the case of many, perhaps most, of these clinics the physicians spend most of their time serving patients on a fee-for-service basis. This may also be true of the 59 dentists who compose the staffs of the private group dental clinics.

Table 13 provides data on the plans which contract with groups of physicians and/or dentists for service. In sum, 41 plans contract with medical and/or dental groups for service. These plans have a total enrollment of 2,767,000 and they contracted with 103 different groups of physicians and/or dentists. Of the 41 plans, 12 are community group practice plans with a total enrollment of 2,670,000. All except one of the remaining plans are employer-employee-union group practice plans.

Forty plans, with a total enrollment of 2,766,000, contract with groups of physicians for medical service. The groups contracted with had a total of 3,954 physicians. Of the 40 plans, 12 were community group practice plans. They had 96 percent of the enrollment in all plans that contracted for group service. Principal among the plans contracting with groups of physicians for service are the five Kaiser plans, each of which contracts with a single group of physicians, and HIP, which contracts with 31 groups. The medical groups which provided service under contract with the community group practice plans had a total of 3,037 physicians.

One employer-employee-union individual practice plan contracted with a group of physicians for some services. All the remaining 27 plans contracting for medical service were employer-employee-union group practice plans. The groups they con-

TABLE 13.—Plans contracting with medical or dental groups for service and number of physicians and dentists in such groups

[Enrollment in thousands]

Type of plan	Plans contracting with medical and/or dental groups			Plans contracting with groups of physicians				Plans contracting with groups of dentists			
	Plans		Number of groups contracted with	Plans		Groups of physicians contracted with		Plans		Groups of dentists contracted with	
	Number	Enrollment		Number	Enrollment	Number of groups	Number of physicians	Number	Enrollment	Number of groups	Number of dentists
All plans	40	2,765.7	102	39	2,764.8	101	3,944	11	42.9	26	124
Community group practice	12	2,671.1	53	12	2,671.1	53	3,037				
Employer-employer-union group practice	28	94.6	49	27	93.7	48	907	11	42.9	26	124
Union-employer welfare fund	7	36.7	16	7	36.7	16	150	5	26.6	14	47
Employer or employer association	11	23.4	13	11	23.4	13	58	2	4.9	4	33
Union	2	2.0	2	1	1.1	1	9	2	2.0	2	34
Employee association	3	16.1	7	3	16.1	7	168	2	9.4	6	10
Employer-employee association	5	16.4	11	5	16.4	11	522				

tracted with contained some 907 physicians. About three-quarters of these physicians provided service to eight employer-employee-benefit association plans, all or virtually all of which were railway association plans. These plans contract with large numbers of physicians in cities and towns along the right of way to give such service as may be needed by sick or injured employees. Most of these physicians are private practitioners in solo or partnership practice. They do not constitute organized medical groups in the sense that the Kaiser or HIP medical groups do.

Eleven plans—all of them employer-employee-union group practice plans with an enrollment of 43,000—contracted with groups of dentists for dental services. The dental groups contracted with contained 124 dentists.[4]

Addition of the number of physicians directly employed on a full or part-time basis by the different plans and the number of physicians in medical groups, with which plans contract for service, results in a total of 8,352 physicians that gave some of their time to serving the enrollees of these plans. Similarly, addition of the number of dentists directly employed by plans (including staff dentists of private group dental clinics) and the dentists in dental groups with which plans contracted results in a total of 574 dentists connected with these plans in one way or another.

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[4] It is possible that some of these dental groups were really assuming the underwriting risk and that the plan should have been classified as a private dental group clinic. The plan was classified as the information provided indicated.

IV. GEOGRAPHICAL DISTRIBUTION

THE HEALTH INSURANCE plans considered in this report (all other than Blue Cross and Blue Shield plans and insurance companies) are largely located in the Middle Atlantic, East North Central and Pacific States, and the majority of persons served belong to plans headquartered in these States. The great majority of plans serve people residing in the area in which the plan has its headquarters. A small number of plans—those of certain larger employer-employee-union organizations—are national in character and serve people residing in many States or the country over. Nevertheless, a large majority of all persons served by all plans reside in the regions mentioned.

Of the 482 plans, 194 are headquartered in the Middle Atlantic States (see table 14). Approximately a third—144—are located in New York State; these plans have almost one-third of the total enrollment of all plans. Another 68 plans, with almost 10 percent of the total enrollment, are located in the East North Central States. Forty plans, with 14 percent of the total enrollment, have their headquarters in the South Atlantic States. Most of the enrollment of these plans is in four large national plans that are headquartered in the District of Columbia or Maryland, namely, the plans of the United Mine Workers Welfare and Retirement Fund, the National Association of Letter Carriers, the National Postal Union, and the United Federation of Postal Clerks. The last three are self-insured plans of Federal employee organizations that are approved carriers under the Federal Employee Health Benefits program.[1] The Pacific States have 70 plans with over 4 million enrollees; 35 of these plans, with more than 3 million enrollees, are in California.

The larger community group practice plans are located in New York, Michigan, Ohio, the District of Columbia, Washington, Oregon, California, and Hawaii. Sixty percent of the total enrollment is in California.

Of the half dozen community individual practice plans of significant size, two are located in New York (Group Health Insurance,

[1] Fourteen Federal employee organization plans offer coverage under this program. However, the great majority of these plans are underwritten by insurance companies and thus do not come within the scope of this report.

Inc. and Group Health Dental Insurance), one in Pennsylvania (the Intercounty Hospital Service Plan), one in California, and one in Oregon.

The employer-employee-union group practice plans are largely located in the Middle Atlantic and Pacific States. New York State is the headquarters of plans that have almost 50 percent of the total enrollment of all plans of this nature; California has plans with almost 10 percent of the total enrollment. Hawaii has a considerable number of such plans, but the total enrollment is small; largely these are plans operated by sugar plantations for their workers.

Of the employer-employee-union individual practice plans, almost half, with one-third of the enrollment, are in the Middle Atlantic States. The East North Central States have 16 percent of the plans with 21 percent of the enrollment. The South Atlantic States, primarily the District of Columbia and Maryland, have 7 percent of the plans with over one-third of the total enrollment (the heavy concentration is due to the four plans located in or near Washington, D.C.). The Pacific States have only a small number of employer-employee-union individual practice plans with a quite small enrollment. Perhaps this is due to the fact that the Blue Cross and Blue Shield plans in these States offer coverage of physician office and home visits and the availability of the Kaiser plans.

Of the 11 private group medical clinic plans, seven, with 92 percent of the total enrollment are in the Pacific States and of these, four, with 81 percent of the total enrollment, are in California. Two of the three private group dental clinic plans are in California, the third is in Washington, D.C.

Of the 10 dental service corporation plans, four, with 99.5 percent of the total enrollment, are in the Pacific States. The plan in California has 84 percent of the total enrollment of all plans of this nature.

ENROLLMENT BY STATE OF RESIDENCE

Of the 482 plans surveyed, 454, with a total enrollment of 9,267,000, were held to be single State plans, i.e., all or almost all of the people served resided in the State in which the plan had its headquarters. Some 28 plans, with an enrollment of 2,937,000, were held to be multiple State plans, i.e., they served people residing in more than one State. Although these multi-State plans were only 6 percent of the total number of plans, their enrollment was 24 percent of the total. In order to develop estimates of the number of residents of each State that were served by the plans, it is

TABLE 14.—Plans and enrollment, by State of plan headquarters

[Enrollment in thousands]

Region and State	Total		Enrollment		Community group practice		Community individual practice		Employer-employee union group practice		Employer-employee union individual practice	
	Number	Percent	Number	Percent	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment	Plans	Enrollment
United States	482	100.0	12,203.5	100.0	23	2,883.5	17	1,807.1	101	1,638.3	317	4,195.8
New England	19	3.9	61.5	.5					3	26.7	15	34.6
Maine	1	.2	1.2	(1)							1	1.2
New Hampshire												
Vermont												
Massachusetts	13	2.7	51.6	.4					2	24.3	11	27.3
honede Island	1	.2	2.4	(1)					1	2.4		
RMnctoCicut	4	.8	6.3	(1)							3	6.1
iddle Atlantic	194	40.3	4,661.3	38.2	2	695.2	5	1,618.9	31	937.8	154	1,403.3
New York	144	29.9	3,952.7	32.4	1	694.2	3	1,396.0	24	775.0	115	1,087.1
New Jersey	17	3.5	114.8	.9	1	1.0	1	15.5	1	4.7	14	93.6
Pennsylvania	33	6.9	593.8	4.9			1	207.4	6	158.1	25	222.6
East North Central	68	14.1	1,160.4	9.5	3	115.0	1	6.6	10	156.8	51	879.4
Michigan	4	.8	102.6	.8	1	76.7					2	23.9
Ohio	24	5.0	736.3	6.1	2	38.3	1	6.6	1	.6	19	690.5
Illinois	18	3.7	206.7	1.7					7	109.3	11	97.4
Indiana	3	.6	12.9	.1							3	12.9
Wisconsin	19	4.0	101.9	.8					2	46.9	16	54.7
West North Central	37	7.7	291.6	2.4	2	22.5			8	129.5	26	183.2
Minnesota	11	2.3	86.8	.7	2	22.5			1	22.0	7	40.9
Iowa	5	1.0	14.4	.1							5	14.4
Missouri	17	3.5	153.0	1.2					6	100.5	11	52.5
North Dakota												
South Dakota	1	.2	7.0	.1					1	7.0		
Nebraska	2	.4	1.9	(1)							2	1.9
Kansas	1	.2	23.5	.3							1	28.5

South Atlantic	40	8.3	1,727.6	14.2	5	84.4	4	33.1	6	62.0	22	1,514.8
Delaware	1	.2	10.5	.1					1	10.5		
Maryland	6	1.3	412.3	3.4	1	5.2			2	15.1	3	392.0
District of Columbia	9	1.9	1,212.8	9.9	1	70.5					7	1,114.3
Virginia	9	1.9	32.6	.3	1	3.0			1	21.2	5	3.1
West Virginia	2	.4	20.3	.2			1	19.4			1	.9
North Carolina	4	.8	3.4	(1)							4	3.4
South Carolina												
Georgia	4	.8	22.2	.2			1	6.9	2	15.2	1	.1
Florida	5	1.0	13.5	.1	2	5.7	2	6.8			1	1.0
East South Central	6	1.2	56.2	.4					2	11.4	4	44.8
Kentucky	1	.2	2.6	(1)							1	2.6
Tennessee	1	.2	25.2	.2							1	25.2
Alabama	3	.6	27.3	.2					1	10.3	2	17.0
Mississippi	1	.2	1.1	(1)					1	1.1		
West South Central	24	5.0	63.7	.5	2	2.8	1	.8	7	42.7	14	17.4
Arkansas	3	.6	11.7	.1					1	9.6	2	2.1
Louisiana	5	1.0	25.8	.2					1	22.0	4	3.8
Oklahoma	3	.6	2.5	(1)	1	2.0					2	.5
Texas	13	2.7	23.7	.2	1	.8	1	.8	5	11.1	6	11.0
Mountain	24	5.0	171.9	1.4			1	52.0	7	77.7	15	37.5
Montana												
Idaho	4	.8	2.2	(1)							4	2.2
Wyoming												
Colorado	6	1.3	70.7	.6			1	52.0	2	11.0	3	7.7
New Mexico	1	.2	.7	(1)							1	.7
Arizona	3	.6	22.8	.2					2	22.5	1	.3
Utah	6	1.3	49.5	.4					3	44.2	2	.6
Nevada	4	.8	26.0	.2							4	26.0
Pacific	70	14.5	4,009.3	32.9	9	1,963.7	5	95.7	27	193.7	16	125.8
Washington	7	1.4	246.4	2.0	2	116.4			1	3.4	1	.5
Oregon	8	1.6	241.7	2.0	1	113.0	2	89.4	1	2.7	2	1.1
California	35	7.3	3,337.3	27.4	5	1,661.3	3	6.3	8	157.5	12	123.4
Alaska												
Hawaii	20	4.2	183.9	1.5	1	73.0			17	30.1	1	.8

[1] Less than 0.05.

necessary, of course, to allocate the enrollees of the multi-State plans by State of residence.

The process of obtaining a count of enrollees of multi-State plans according to State of residence involved considerable additional clerk and machine time. In order to keep the dimensions of the work within reasonable limits, certain criteria were adopted as to plans that would be considered multi-State for the purposes of this report. It was determined that no plan would be considered a multi-State plan unless it served more than 10,000 persons and unless at least 10 percent of its enrollment resided in a State different from State of plan headquarters. If a plan had less than 10,000 members and served people residing in two or more States, all of its enrollment was assumed to be in the State of its plan headquarters. Similarly, if a plan had more than 10,000 enrollees, but more than 90 percent of the people served resided in the State in which the plan had its headquarters, the plan was considered to be a single State one and all of its enrollment was credited to that State.

Appendix table D shows the enrollment of single State plans by State and the enrollment of multi-State plans both by State of plan headquarters and by State of residence, and the enrollment of all plans by State of plan headquarters and by State of residence. The distribution of the enrollment of multi-State plans by State of residence has the effect of considerably increasing overall enrollment in the New England Sates, greatly diminishing enrollment in the South Atlantic States, and increasing enrollment in the East South Central, West South Central and Mountain States; it leaves the other regions relatively unchanged overall.

TABLE 15.—Enrollment covered for specified benefits, by State of residence

Region and State	Any benefit		Hospital care		Surgery		In-hospital medical	
	Number (in thousands)	Percent	Number (in thousands)	Percent	Number (in thousands)	Percent	Number (in thousands)	Percent
United States	12,203.5	100.0	7,276.7	.100.0	8,751.5	100.0	8,492.5	100.0
New England	206.1	1.7	172.3	2.4	136.5	1.6	133.0	1.6
Maine	6.5	.1	5.3	.1	5.3	.1	5.3	.1
New Hampshire	4.0	(1)	4.0	.1	4.0	(1)	4.0	(1)
Vermont	9.0	.1	9.0	.1	5.9	.1	9.0	.1
Massachusetts	140.6	1.1	114.9	1.6	90.0	1.0	79.2	1.0
Rhode Island	11.7	.1	9.3	.1	8.6	.1	6.6	.1
Connecticut	34.3	.3	29.8	.4	22.7	.3	28.9	.3
Middle Atlantic	4,977.5	40.8	2,152.4	29.6	3,745.2	42.8	3,271.4	38.5
New York	3,902.4	32.0	1,246.8	17.1	3,094.7	35.4	2,738.7	32.2
New Jersey	175.7	1.4	122.6	1.7	87.2	1.0	84.2	1.0
Pennsylvania	899.4	7.4	783.0	10.8	563.3	6.4	448.5	5.3
East North Central	1,168.1	9.6	1,048.7	14.4	856.2	9.8	1,031.9	12.1
Michigan	158.5	1.3	156.4	2.1	147.9	1.7	153.9	1.8
Ohio	493.2	4.0	463.7	6.4	254.0	2.9	419.8	4.9
Illinois	323.4	2.7	247.5	3.4	278.6	3.2	281.0	3.3
Indiana	64.9	.5	64.8	.9	57.8	.7	63.1	.7
Wisconsin	128.1	1.1	116.3	1.6	117.9	1.3	114.1	1.4

TABLE 15.—Enrollment covered for specified benefits, by State of residence—Continued

Region and State	Any benefit		Hospital care		Surgery		In-hospital medical	
	Number (in thousands)	Percent	Number (in thousands)	Percent	Number (in thousands)	Percent	Number (in thousands)	Percent
West North Central	366.6	3.0	312.0	4.3	337.2	3.8	340.7	4.0
Minnesota	79.2	.6	75.5	1.0	76.8	.9	77.2	.9
Iowa	41.3	.4	41.2	.6	40.8	.5	41.2	.5
Missouri	147.0	1.2	96.3	1.3	135.4	1.5	126.4	1.5
North Dakota	4.5	(1)	4.5	.1	4.5	.1	4.5	.1
South Dakota	10.9	.1	10.8	.1	10.8	.1	10.8	.1
Nebraska	26.0	.2	26.1	.4	21.0	.2	23.5	.3
Kansas	57.7	.5	57.7	.8	47.9	.5	57.1	.6
South Atlantic	616.3	5.0	497.1	6.8	503.2	5.7	502.7	5.9
Delaware	14.3	.1	3.7	(1)	3.7	(1)	3.1	(1)
Maryland	81.2	.7	56.9	.8	67.0	.8	68.7	.2
District of Columbia	78.9	.6	11.4	.2	50.0	.6	48.3	.
Virginia	79.7	.6	64.4	.9	70.7	.8	73.6	.1
West Virginia	204.5	1.7	203.5	2.8	184.1	2.1	184.1	2.4
North Carolina	33.4	.3	33.1	.4	32.0	.4	32.9	.8
South Carolina	13.7	.1	13.7	.2	13.1	.1	13.6	.
Georgia	59.3	.5	59.2	.8	43.4	.5	36.0	.4
Florida	51.3	.4	51.2	.7	39.2	.4	42.4	.5
East South Central	266.3	2.2	266.3	3.7	238.7	2.7	240.8	2.8
Kentucky	85.8	.7	85.8	1.2	80.2	.9	85.8	1.
Tennessee	82.8	.7	82.8	1.1	79.5	.9	57.6	.7
Alabama	85.3	.7	85.3	1.2	67.2	.8	85.0	1.0
Mississippi	12.4	.1	12.4	.2	11.8	.1	12.4	.1
West South Central	223.1	1.8	191.9	2.6	184.4	2.1	202.2	2.4
Arkansas	34.7	.3	34.7	.5	34.4	.4	34.7	.4
Louisiana	56.4	.5	31.3	.4	47.6	.5	48.5	.6
Oklahoma	28.6	.2	28.6	.4	22.1	.3	28.0	.3
Texas	103.4	.8	97.3	1.3	80.3	.9	91.0	1.1
Mountain	223.7	1.8	218.2	3.0	208.8	2.4	218.2	2.6
Montana	10.5	.1	10.5	.1	10.5	.1	10.5	.1
Idaho	11.2	.1	11.1	.2	11.1	.1	11.1	.1
Wyoming	10.0	.1	9.5	.1	9.5	.1	9.5	.1
Colorado	89.3	.7	89.3	1.2	88.9	1.0	89.3	1.1
New Mexico	8.2	.1	8.2	.1	8.2	.1	8.2	.1
Arizona	42.6	.3	42.3	.6	33.3	.4	42.3	.5
Utah	22.2	.2	17.6	.2	17.6	.2	17.6	.2
Nevada	29.7	.2	29.7	.4	29.7	.4	29.7	
Pacific	4,155.7	34.1	2,417.9	33.2	2,541.2	29.1	2,551.6	30.1
Washington	288.5	2.4	174.7	2.4	174.5	2.0	175.0	2.1
Oregon	242.7	2.0	208.1	2.9	206.6	2.4	207.1	2.4
California	3,439.3	28.2	1,929.9	26.5	2,055.8	23.5	2,065.2	24.3
Alaska	.5	(1)	.5	(1)	.5	(1)	.5	(1)
Hawaii	184.7	1.5	104.7	1.4	103.8	1.2	103.8	1.2

[1] Less than 0.05.

Table 15 shows the enrollment of the plans for any benefit and for hospital care, surgery, and in-hospital medical visits, by State of residence. Of the total persons served for hospital care, 30 percent reside in the Middle Atlantic States, 14 percent in the East North Central States and 33 percent in the Pacific States. The State distribution of the enrollment for medical services is rather different. Forty-three percent of the total enrollment for surgical service is in the Middle Atlantic States, 10 percent in the East North Central States, and 29 percent in the Pacific States. The explanation of the difference is the presence in New York of HIP and Group Health Insurance, both of which cover physician service but not hospital care.

ENROLLMENT OF PERSONS UNDER AGE 65

For reasons previously given, data on the number of persons under age 65 residing in each State who have health insurance coverage of various services are desirable. Such data are provided in appendix E. The figures are estimates since a number of plans with about 15 percent of the total enrollment did not know how many of their enrollees were under and over age 65. For all practical purposes the regional and State distribution of the enrollees under age 65 is the same as that for enrollees of all ages.

V. FINANCES

THE HEALTH INSURANCE plans here considered (all other than Blue Cross and Blue Shield plans and insurance companies) had a total income of $779 million in 1968. Of this amount $733 million came from subscriber dues (in the case of the community plans) and employer-employee contributions (in the case of the employer-employee-union plans), $26 million came from fees or charges for health services, and $19 million from investment income and other sources (table 16). The plans expended $712 million—91.5 percent of total income—in providing benefits, and $47 million—6.0 percent of total income—for administration. They had a net income, i.e., surplus of income over expenditures, of $20 million, equal to 2.5 percent of income.

Of the total income of all plans, almost a third was received by the community group practice plans and almost 40 percent by the employer-employee-union individual practice plans. Employer-employee-union group practice plans received 14 percent of the total income and community individual practice plans 9 percent. The dental service corporation plans had a total income of $36 million, almost 5 percent of the total. The income of the private group medical and dental clinic plans amounted to less than 2 percent of the total.

The community group practice plans in 1968 spent 95.7 percent of total income in providing health services, and 5.1 percent for administration. The net deficit was primarily due to the unfavorable experience in this year of two of the larger plans. The imbalance will be corrected by increasing subscriber charges.

The financial experience of the various groups of plans was, in general, fairly similar. The community group practice plans had the highest benefit expense ratio—95.7 percent; the dental service corporation plans the lowest—82.5 percent. This last, perhaps, is temporary, being partly due to rapid growth when income outpaces benefit expense. All of the different types of plans had about the same administrative expense ratio—5 to 7 percent, excepting the community individual practice plans which had an operating expense ratio of 13 percent. Both the community group practice and community individual practice plans had small deficits in this year. Most of the other plans had small net income ratios, with the

dental service corporation plans showing the largest—11 percent.

The above data relate wholly to what may be termed the private or regular operations of the plans and are exclusive of the expense of providing services to aged persons under the Medicare program and of amounts (income) received from the Social Security Administration to reimburse them for the cost of providing such services.[1] One plan, HIP, provided service to Medicaid beneficiaries; its expense and income do not include the cost of providing this care and income received therefor.

It may be noted at this point that data provided by the Bureau of Health Insurance of the Social Security Administration show that in 1968 23 group practice plans (eight community group practice plans with the four Kaiser plans considered as a single plan, 13 employer-employee-union group practice plans, and two private group medical clinic plans) were reimbursed on a per capita basis for the cost of providing stipulated Medicare benefits to Medicare beneficiaries. The aggregate payments to all of these plans amounted to $21.2 million. These are plans which elected to be reimbursed by the Social Security Administration for the cost of care provided to Medicare beneficiaries. Various other plans, of course, provided service to Medicare beneficiaries but elected to be paid on a fee basis for each service provided.

LIMITATIONS OF THE FINANCIAL EXPERIENCE DATA

When considering the financial data in table 16, the reader should be aware of their nature and limitations. Each group of plans will be discussed in turn.

The data for the community group practice plans may be regarded, by and large, as quite accurate. However, an element of estimation enters into determination of the administrative expense of some of the plans. Where a single organization directly provides health care on a prepayment basis through its own salaried personnel and facilities, it encounters difficulties in separating the expense of administering the prepayment program from the expense of administering the medical program.

Those community group practice plans, which directly provide care through their own facilities and staff, have not as yet arrived at any uniform formula to be used by all plans for determining what items of expense are to be included as expenses of administering the prepayment program and what are to be included as

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[1] The questionnaire specifically asked the plans to give their income exclusive of income received or receivable from the Federal Government under Medicare and to give their expenses exclusive of reimbursable expense in providing care under Medicare.

TABLE 16.—Income and expenditures, by type of plan

Type of plan	Income (in thousands)				Expenditures						Net income	
					Total		Health care benefits		Administrative			
	Total	Subscriber dues employer-employee contributions	Fees or charges for health services	Investment and other income	Amount (in thousands)	Percent of total income	Amount (in thousands)	Percent of total income	Amount (in thousands)	Percent of total income	Amount (in thousands)	Percent of total income
All plans	$778,585	$733,459	$26,086	$19,040	$758,739	97.5	$712,048	91.5	$46,691	6.0	$19,846	2.5
Community group practice	247,666	226,738	16,660	4,268	249,674	100.8	237,053	95.7	12,621	5.1	−2,008	−.8
Community individual practice	70,272	69,439	6	827	70,425	100.2	61,254	87.2	9,171	13.0	−153	−.2
Employer-employee-union group practice	108,472	99,998	3,623	4,851	105,476	97.2	99,256	91.5	6,220	5.7	2,996	2.8
Union employer welfare fund	48,402	45,486	1,883	1,033	47,435	98.0	44,361	91.6	3,074	6.4	967	2.0
Employer or employer association	7,734	7,729	5	----	7,738	100.1	7,404	95.7	334	4.4	−4	−.1
Union	3,629	3,629	----	(1)	3,747	103.2	3,523	97.1	224	6.1	−118	−3.2
Employee association	30,929	27,139	1,044	2,746	30,184	97.6	28,380	91.8	1,804	5.8	745	2.4
Employer-employee association	17,778	16,015	691	1,072	16,372	92.1	15,588	87.7	784	4.4	1,406	7.9
Employer-employee-union individual practice	302,486	294,868	1,157	6,461	287,462	95.0	271,917	89.9	15,545	5.1	15,024	5.0
Union-employer welfare fund	139,004	135,080	260	3,664	130,458	93.8	123,050	88.5	7,408	5.3	8,546	6.2
Employer or employer association	53,292	52,735	----	557	52,331	98.2	49,650	93.2	2,681	5.0	961	1.8
Union	84,288	82,483	331	1,474	79,892	94.8	76,137	90.3	3,755	4.5	4,396	5.2
Employee association	17,054	16,225	416	413	16,357	95.9	15,012	88.0	1,345	7.9	697	4.1
Employer-employee association	8,848	8.345	150	353	8,424	95.2	8,068	91.2	356	4.0	424	4.8
Private group medical clinic	11,951	6,854	4,082	1,015	11,894	99.5	11,300	94.5	594	5.0	57	.5
Private group dental clinic	1,240	744	496	----	1,217	98.1	1,156	93.2	61	4.9	23	1.9
Dental service corporation	36,498	34,818	62	1,618	32,591	89.3	30,112	82.5	2,479	6.8	3,907	10.7
	Percentage distribution											
All plans	100.0	100.0	100.0	100.0	100.0	----	100.0	----	100.0	----	100.0	----
Community group practice	31.8	30.9	63.9	22.4	32.9	----	33.3	----	27.0	----	−10.1	----
Community individual practice	9.0	9.5	(2)	4.3	9.3	----	8.6	----	19.6	----	−.8	----
Employer-employee-union group practice	13.9	13.6	13.9	25.5	13.9	----	13.9	----	13.3	----	15.1	----
Employer-employee-union individual practice	38.9	40.2	4.4	33.9	37.9	----	38.2	----	33.3	----	75.7	----
Private group medical clinic	1.5	.9	15.6	5.3	1.6	----	1.6	----	1.3	----	.3	----
Private group dental clinic	.2	.1	1.9	----	.2	----	.2	----	.1	----	.1	----
Dental service corporation	4.7	4.7	.2	8.5	4.2	----	4.2	----	5.3	----	19.7	----

[1] Less than $500.
[2] Less than 0.05.

expenses of administering the medical program.[2] The plans now determine and report administrative expense for their prepayment programs as seems best in each instance and some include certain items of expense which probably should not be included, and vice versa.

This problem, of course, does not arise where the plan, as in the case of the Health Insurance Plan of Greater New York, functions primarily as a prepayment organization and care is provided through contract with more or less autonomous medical groups. The same is true in lesser degree of the Kaiser plans although here the accounting problems are more difficult.

The community individual practice plans do not have this problem. They do not directly provide service but pay private practitioners and hospitals for care provided to their subscribers, so there is no problem in segregating these payments to physicians, hospitals, etc. from the administrative expenses of the plan per se.

The data for the employer-employee-union plans, whether they provide service through group or individual practice, must be regarded as approximate. In general, the most accurate item is the expenditure for health care benefits. The data on total income and administrative expense are, in many cases, estimates. This is especially true as regards plans operated by union-employer welfare funds.

Welfare funds receive virtually their entire income from contributions of employers. Out of this income the funds provide various benefits, some of which may be provided through purchase of insurance from a carrier. Thus, a welfare fund may purchase life insurance from an insurance company; it may provide disability benefits either directly, i.e., through self-insurance or through purchase of insurance from a carrier. It may provide certain health benefits such as hospital care and surgery through insurance with Blue Cross, Blue Shield, or an insurance company. It may provide other health benefits, say, physician office and home visits, or drugs, or vision care, on a self-insured basis and its expenditures for these self-insured benefits, whether provided through a health center and salaried medical or dental personnel or by payments to private practitioners, may amount to only a small part of its total benefit outlays. The amounts which the fund reports for administrative expenses are for administration of a variety of benefits, including purchase of insurance for some.

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[2] This would require agreement on what items of expense should be charged to the prepayment side of the program and what items of expense chargeable to the provision of medical service, including medical program administration. It would be helpful in the future for the Group Health Association of America, the association to which the plans belong, to take leadership in developing such agreement.

The procedure used in such cases to estimate income and administrative expense for the self-insured health care benefits was to determine the percentage that expenditures for the self-insured health care benefits were of the total expenditures for all benefits, including premiums paid for insured benefits, and to apply this percentage to the total income and the total administrative expenses of the fund.[3]

Where the expenditures for self-insured health benefits were quite small in relationship to expenditures for all other benefits, this procedure was not used. Instead, administrative expense was calculated by this process or assumed to be 5 percent. This amount was added to the expenditures for self-insured health benefits and income was assumed to be equal to the sum with the plan showing no net income.

A special problem arose in the case of some employer-employee-union group practice plans where total expense for self-insured health benefits consisted of the expense of operating the health center (salaries of personnel, cost of supplies, maintenance of the facility, etc.) and no separate administrative expense was shown. In this case it was assumed that the administrative expense of the prepayment sector of the health center program was equal to 5 percent of the total expended. Hence, this amount was shown for administrative expense and the remainder was shown as expenditure for providing health care benefits.

Where a health center provided both physician service and dental care, a rough allocation of expense was made on the basis of the relation of the aggregate salaries paid to physicians and dentists, respectively (see alternate F 2 item on questionnaire).

Some employer sponsored plans made payments to hospitals and physicians for charges incurred by employees or payments to employees to reimburse them for charges incurred, these payments being made out of the general funds of the employer. The questionnaire showed no income for the program and nothing for administrative expense. In such case, it was assumed that the plan had an administrative expense equal to 5 percent of benefit

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[3] For example, take a fund that had a total income of $1,000,000, spent $100,000 for life insurance, $300,000 for self-insured disability benefits, $300,000 for premiums for insured health care benefits, $300,000 for self-insured health care benefits, and $50,000 for administration, leaving a net income of $50,000. The expenditures for self-insured health care benefits was one-third of total expenditures for all benefits—$900,000. Accordingly, it was assumed that the income for self-insured health care benefits was one-third of $1,000,000 or $333,000, that self-insured health care benefits was $300,000 as given, that administrative expenses for the health care benefits were one-third of $50,000 or $16,660 and that net income was one-third of $50,000, or $16,660.

expenditures.[4] The plan's income, it was assumed, then was equal to the sum of benefit expenditures and administrative expense, with the plan having no net income.

A number of the smaller private medical group clinics (where the income from the prepayment program was small in relation to the clinic's total income) reported only the income from their prepayment program; they did not know, or at any rate did not report, what it cost them to provide the covered services to the prepayment enrollees or the expense of administering the prepayment program. In this case, it was assumed that benefit expense was equal to 95 percent and administrative expense to 5 percent of the prepayment income, with the plan having no net income. The larger clinics generally provided data on the cost of providing service to the enrolled population and the administrative expense of the program.

When necessary, similar procedures were used for the private dental group clinics.

The figures for the dental service corporations may be regarded as accurate since these plans know their subscriber income, their claim expense, and their administrative expense. The figures for some of the new and smaller plans may not be very meaningful since the financial experience of a new plan may be quite different from that of a mature one.

DISTRIBUTION OF BENEFIT EXPENDITURES BY TYPE OF SERVICE

Table 17 shows the expenditures of the plans for provision of the various types of service or benefits. Of the $712 million expended for benefits by all plans, 41 percent were for hospital care, 48 percent for physician service, 7 percent for dental care, 3 percent for drugs (outside of the hospital) and 1 percent, in the aggregate, for all other types of service or benefits, namely, visiting nurse service, special duty nursing, eyeglasses, nursing home care, and other.

The distribution of benefit expenditures of the different groups of plans varies widely. The community group practice plans spent 33 percent of their total benefit expenditures for hospital care, 66 percent for physician service, and less than 1 percent for drugs and all other types of care. The comparatively low proportion going for hospital care and the high proportion spent for physician service is mainly due to the fact that one large plan, HIP,

[4] The employer may assign to an employee the task of paying claims and assume no administrative expense is incurred. If account were taken of the time of this employee, his space, expense for telephone, mailing, etc. the total administrative expense might well be at least 5 percent.

TABLE 17.—Benefit expenditures, by type of service

Type of service	All plans	Type of plan						
		Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Private group medical clinic	Private group dental clinic	Dental service corporation
	Expenditures (in thousands)							
Total	$712,048	$237,053	$61,254	$99,256	$271,917	$11,300	$1,156	$30,112
Hospital care	292,373	77,427	14,825	39,208	160,272	641	—	—
Physician service	343,147	157,451	40,842	45,419	89,436	9,999	—	—
Dental care	49,043	—	4,328	7,700	5,747	—	1,156	30,112
Drugs outside hospital	20,409	1,728	829	4,726	12,644	482	—	—
Visiting nurse service	493	15	21	253	204	—	—	—
Special duty nursing	1,430	19	356	123	929	3	—	—
Eyeglasses	3,096	304	—	1,486	1,135	171	—	—
Nursing home care	662	52	(1)	127	483	—	—	—
Other service	1,395	57	53	214	1,067	4	—	—
	Percentage distribution by type of service							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	41.0	32.7	24.2	39.5	58.9	5.7	—	—
Physician service	48.2	66.4	66.7	45.8	32.9	88.5	—	—
Dental care	6.9	—	7.1	7.8	2.1	—	100.0	100.0
Drugs outside hospital	2.9	.7	1.3	4.8	4.7	4.3	—	—
Visiting nurse service	.1	(2)	(2)	.2	.1	—	—	—
Special duty nursing	.2	(2)	.6	.1	.3	(2)	—	—
Eyeglasses	.4	.1	—	1.5	.4	1.5	—	—
Nursing home care	.1	(2)	(2)	.1	.2	—	—	—
Other service	.2	(2)	.1	.2	.4	(2)	—	—
	Percentage distribution by type of plan							
Total	100.0	33.3	8.6	13.9	38.2	1.6	0.2	4.2
Hospital care	100.0	26.5	5.1	13.4	54.8	.2	—	—
Physician service	100.0	45.9	11.9	13.2	26.1	2.9	—	—
Dental care	100.0	—	8.8	15.7	11.7	—	2.4	61.4
Drugs outside hospital	100.0	8.5	4.1	23.1	61.9	2.4	—	—
Visiting nurse service	100.0	3.0	4.3	51.3	41.4	—	—	—
Special duty nursing	100.0	1.3	24.9	8.6	65.0	.2	—	—
Eyeglasses	100.0	9.8	—	48.0	36.7	5.5	—	—
Nursing home care	100.0	7.8	(2)	19.2	73.0	—	—	—
Other service	100.0	4.1	3.8	15.3	76.5	.3	—	—

[1] Less than $500. [2] Less than 0.05.

does not cover hospital care, and that these plans provide comprehensive physician service, which in the aggregate, costs more than hospital care.

The community individual practice plans spent only one-quarter of their benefit expenditures for hospital care, 67 percent for physician service, and 7 percent for dental care. The large proportion spent for physician service is due to the predominance in this group of Group Health Insurance, Inc., which covers physician service only and does not cover hospital care.

Among the employer-employee-union group practice plans, 40 percent of benefit expenditures went for hospital care and 46 percent for physician service, with 8 percent going for dental care, 5 percent for drugs outside of the hospital and 2 percent for other benefits, chiefly eyeglasses. The employer-employee-union individual practice plans spend relatively much more for hospital care—59 percent—and less for physician service—33 percent—and dental care 2 percent. However, they also spent a significant proportion of the total for drugs and other types of care.

The private group medical clinic plans, as might be expected, spent a large proportion of all benefit expenditures for provision of physician service—89 percent—with relatively small amounts going for hospital care and drugs. (Most of these plans do not cover hospital care.) The private group dental clinics and the dental service corporations made expenditures only for dental care.

SOME LIMITATIONS OF THE DATA

The data on benefit expenditures of some plans are estimates. Some group practice plans which have their own hospitals did not provide data on the distribution of benefit expenditures as between hospital care and physician service; this was estimated on the basis of the relationships in other similar plans. Some group practice plans which provided drugs, either on a prepayment or charge basis, may have understated their expenditures for drugs. Until these benefits are more widely provided, the practices of the plans in calculating and reporting expenditures for this item will vary widely and not be consistent from one plan to another.

Where a group practice plan provided both medical and dental service, it was frequently unable to report the outlay for each type of service. This had to be estimated on the basis of the relative aggregate salaries paid to physicians and dentists.

Where a plan provided benefits through payments to hospitals and private practitioners (or reimbursement of covered persons for charges incurred), it was generally able to report the exact expenditures for each type of service. However, where a plan

provides benefits on a major medical basis, i.e., reimbursing covered persons for, say, 80 percent of expenditures over and above a deductible, difficulties are encountered. Some of these plans were unable to provide a breakdown of their benefit expenditures and this had to be estimated on the basis of the experience of other plans and insurance companies that provide like benefits under similar arrangements.

While the distribution of benefit expenditures of some plans had to be estimated on one basis or another, it is believed that the general picture presented by these figures is accurate.

BENEFIT EXPENDITURES PER ENROLLEE

Table 18 presents data on the benefit expenditures of the plans for specified services per person enrolled for those services. These data are more meaningful than overall benefit expenditures of the different types of plans per person enrolled since the plans of a given group do not all cover the same services.

TABLE 18.—Expenditures for specified benefits for persons covered

Type of plan	Hospital care	Physician service	Drugs	Dental care
All plans	$40.18	$39.21	$3.42	$17.83
Community group practice	36.82	54.78	.72	----
Community individual practice	36.70	32.47	1.96	14.24
Employer-employee-union group practice	42.62	43.93	4.75	16.21
Employer-employee-union individual practice	41.86	25.98	6.13	13.00
Private group medical clinic	32.05	69.92	4.23	----
Private group dental clinic				26.88
Dental service corporation				20.26

The community group practice plans, it will be seen, spent $36.82 for hospital care per person enrolled for this service.[5] The size and relationship of these two figures is of interest in comparison with analogous figures for the Blue Cross-Blue Shield plans, which in 1968 spent $49.11 for hospital care per person enrolled and $19.63 for physician service per person covered for this service.[6]

The expenditures of the different plans for drug benefits per

[5] Since the hospital coverage provided by the community group practice plans is certainly as extensive if not indeed more extensive than the coverage provided by the Blues, the lower outlay of the community group practice plans for hospital care per person covered suggests that the provision of comprehensive physician service in a group practice prepayment setting pays off in keeping patients out of the hospital and lower expenditures for this service. The higher expenditures of the group practice plans for physician service is due, of course, to the fact that they are providing comprehensive coverage of physician service whereas the Blue Shield plans, with some few exceptions, do not cover physician office and home visits.

[6] Louis S. Reed, "Private Health Insurance, 1968: Enrollment, Coverage and Financial Experience," op. cit.

person covered are probably not significant since the degree of coverage varies so widely. The substantial expenditures for dental care per person covered for this benefit, particularly when one takes into account that the coverages provided are far from complete, emphasize the expensiveness of dental care as an insured benefit, at least under present methods of giving this service.

Compared with Blue Cross-Blue Shield and insurance companies, the plans considered in this report spent more proportionately for physician care, less for hospital care, and more for type of care other than hospital care and physician service. The comparison is made below:

Percent distribution of benefit expenditures[1]

	The plans surveyed	Blue Cross-Blue Shield	Insurance companies
Total	100.0	100.0	100.0
Hospital care	41.0	71.5	59.9
Physician service	48.2	25.7	34.2
Dental care	6.9	.1	1.2
Other types of care	3.9	2.7	4.7

[1] Data for Blue Cross and Blue Shield plans are from Louis S. Reed, op. cit.

DISTRIBUTION OF INCOME AND BENEFIT EXPENSE BY STATE

The first four columns of table 19 show the distribution by region and State of the income and benefit expenditures of the plans according to State of plan headquarters. The next four columns show income and benefit expenditure by State of residence of the enrollees. In the latter set of figures the income and benefit

TABLE 19.—Income and benefit expenditures, by State of plan headquarters and of enrollee residence

[In thousands]

Region and State	By plan headquarters				By residence			
	Income		Benefit expenditures		Income		Benefit expenditures	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
United States	$778,585	100.0	$712,048	100.0	$778,585	100.0	$712,048	100.0
New England	2,693	.3	2,006	.3	11,668	1.5	10,214	1.4
Maine	6	(1)	5	(1)	436	.1	400	.1
New Hampshire					336	(1)	307	(1)
Vermont					555	.1	494	.1
Massachusetts	2,347	.3	1,781	.2	7,560	1.0	6,571	.9
Rhode Island	20	(1)	18	(1)	612	.1	556	.1
Connecticut	320	(1)	202	(1)	2,169	.2	1,886	.2
Middle Atlantic	200,145	25.7	176,749	24.8	234,949	30.2	209,703	29.5
New York	164,602	21.2	144,647	20.3	172,323	22.1	151,946	21.4
New Jersey	8,085	1.0	7,027	1.0	10,361	1.4	9,434	1.3
Pennsylvania	27,458	3.5	25,075	3.5	52,265	6.7	48,323	6.8
East North Central	82,451	10.6	75,225	10.6	89,069	11.4	80,930	11.4
Michigan	8,957	1.1	8,145	1.1	13,446	1.7	12,279	1.7
Ohio	48,208	6.2	44,891	6.3	34,435	4.4	31,585	4.4
Illinois	16,066	2.1	13,943	2.0	25,321	3.2	22,697	3.2
Indiana	943	.1	791	.1	5,470	.7	4,984	.7
Wisconsin	8,277	1.1	7,455	1.1	10,397	1.4	9,385	1.3

TABLE 19.—Income and benefit expenditures, by State of plan headquarters and of enrollee residence—Continued

[In thousands]

Region and State	By plan headquarters				By residence			
	Income		Benefit expenditures		Income		Benefit expenditures	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
West North Central	26,830	3.5	24,377	3.4	33,546	4.3	30,702	4.3
Minnesota	7,668	1.0	6,909	1.0	6,984	.9	6,180	.9
Iowa	852	.1	822	.1	3,203	.4	2,989	.4
Missouri	13,378	1.7	12,108	1.7	12,195	1.6	11,121	1.5
North Dakota					446	.1	425	.1
South Dakota	538	.1	488	.1	851	.1	773	.1
Nebraska	57	(1)	59	(1)	2,773	.3	2,646	.4
Kansas	4,337	.6	3,991	.5	7,094	.9	6,568	.9
South Atlantic	152,062	19.5	141,543	19.9	48,022	6.2	45,020	6.3
Delaware	193	(1)	183	(1)	461	.1	433	.1
Maryland	41,793	5.4	37,530	5.3	5,432	.7	4,980	.7
District of Columbia	104,776	13.4	99,148	13.9	4,447	.6	4,085	.6
Virginia	2,949	.4	2,494	.4	6,646	.8	6,214	.9
West Virginia	646	.1	580	.1	20,467	2.6	19,507	2.7
North Carolina	71	(1)	96	(1)	2,334	.3	2,192	.3
South Carolina					1,007	.1	935	.1
Georgia	767	.1	657	.1	3,410	.4	3,107	.4
Florida	867	.1	855	.1	3,818	.5	3,567	.5
East South Central	4,778	.6	4,500	.6	25,251	3.2	23,529	3.3
Kentucky	156	(1)	148	(1)	9,335	1.2	8,674	1.2
Tennessee	2,586	.3	2,462	.3	7,397	.9	6,911	1.0
Alabama	1,993	.2	1,829	.3	7,347	.9	6,881	.9
Mississippi	43	(1)	61	(1)	1,172	.2	1,063	.1
West South Central	5,232	.7	4,767	.7	16,908	2.2	15,406	2.2
Arkansas	436	.1	409	.1	2,406	.3	2,141	.3
Louisiana	930	.1	806	.1	3,188	.4	2,834	.4
Oklahoma	363	(1)	372	.1	2,024	.3	1,923	.3
Texas	3,503	.4	3,180	.4	9,290	1.2	8,508	1.2
Mountain	17,351	2.2	16,392	2.3	20,723	2.7	19,436	2.7
Montana					1,127	.1	1,091	.1
Idaho	191	(1)	199	(1)	1,428	.2	1,390	.2
Wyoming					1,258	.2	1,215	.2
Colorado	4,542	.6	4,031	.6	6,371	.8	5,759	.8
New Mexico	35	(1)	32	(1)	768	.1	720	.1
Arizona	3,785	.5	3,673	.5	5,670	.7	5,440	.8
Utah	7,379	.9	7,179	1.0	2,171	.3	2,061	.3
Nevada	1,419	.2	1,278	.2	1,930	.3	1,760	.2
Pacific	287,043	36.9	266,489	37.4	298,449	38.3	277,109	38.9
Washington	18,344	2.4	16,703	2.3	22,434	2.9	20,561	2.9
Oregon	18,948	2.4	16,970	2.4	19,597	2.5	17,619	2.5
California	237,558	30.5	222,032	31.2	244,110	31.3	228,037	32.0
Alaska					54	(1)	51	(1)
Hawaii	12,193	1.6	10,784	1.5	12,254	1.6	10,840	1.5

[1] Less than 0.05.

expenditures of the multi-State plans have been distributed according to the distribution of their enrollees by State of residence. It was assumed in doing this that the income and benefit expenditures are distributed in the same manner as the enrollees, which is probably not always the case exactly, but will hold approximately.

The data show, as would be expected, the predominance of these plans in the Middle Atlantic and Pacific States. Thus, 30 percent of the income of the plans (using the distribution by State of residence) is derived from persons residing in the Middle Atlantic States, 11 percent from those in the East North Central States, and 38 percent from persons in the Pacific States. Benefit expenditures are distributed in approximately the same fashion.

VI. ARRANGEMENTS FOR DRUGS AND EYEGLASSES

SINCE HEALTH INSURANCE coverage of drugs and eyeglasses is on the increase, the provisions of these plans as regards these two items of care are of interest. In addition, coverage of these items has special problems which makes separate discussion desirable.

Tables 20 and 21 give data on the extent to which the plans cover or furnish drugs and eyeglasses and the nature of the arrangements. The data are compiled from section H of the questionnaire which asked, "If your plan includes drugs and/or eyeglasses in its prepayment program or makes these available to covered persons, please briefly describe arrangements below." The figures resulting from tabulation of the replies do not agree exactly as regards number of plans, or closely as regards enrollment, with those shown in tables 5, 6, and 7, which were based on enrollment reported for specified services.

The discrepancies are due to a number of factors. A plan that covered drugs (or eyeglasses) "on prepayment basis" for some of its enrollees and "on other basis" for other enrollees was, in effect, entered twice in tables 5 and 6, but only once in table 20. The number of enrollees reported covered on each basis is shown in tables 5 and 6, whereas in table 20, if the plan was classified as providing drugs on, say, a prepayment basis, the plan's entire enrollment was placed in this classification. The line between providing drugs (or eyeglasses) on a prepayment basis and providing them on a reduced charge basis is a fuzzy one. If drugs (or eyeglasses) are provided by the plan at charges appreciably below cost, then the difference comes out of the prepayment program, which in effect is subsidizing the provision of drugs and, perhaps, it is fair to say that drugs are being provided under the prepayment program. Hence, different plans with about the same arrangements might classify themselves differently or have been differently coded on the basis of the information provided. Furthermore, while considerable care was taken to code consistently the information provided under sections D and H of the questionnaire, it is possible that consistency was not achieved in all cases.

TABLE 20.—Arrangements for provision of drugs [1]

Arrangements	All plans		Community group practice		Community individual practice		Employer-employee-union group practice		Employer-employee-union individual practice		Private group medical clinic	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
	Plans											
All plans	482	100.0	23	100.0	17	100.0	101	100.0	317	100.0	11	100.0
Some provision for drugs	156	32.4	17	73.9	5	29.4	57	56.4	74	23.3	3	27.3
Own pharmacy	63	13.1	14	60.9	1	5.9	41	40.6	5	1.6	2	18.2
Totally covered by prepayment	24	5.0	4	17.4	----	----	17	16.8	2	.6	1	9.1
Partially covered by prepayment	18	3.7	7	30.4	----	----	10	9.9	----	----	1	9.1
Not covered under prepayment but available at reduced cost	21	4.4	3	13.0	1	5.9	14	13.9	3	.9	----	----
No pharmacy	93	19.3	3	13.0	4	23.5	16	15.8	69	21.8	1	9.1
Totally covered by prepayment	29	6.0	1	4.3	1	5.9	11	10.9	16	5.0	----	----
Partially covered by prepayment	50	10.4	2	8.7	2	11.8	3	3.0	43	13.6	----	----
Not covered under prepayment but available at reduced cost	14	2.9	----	----	1	5.9	2	2.0	10	3.2	1	9.1
No provision for drugs	326	67.6	6	26.1	12	70.6	44	43.6	243	76.7	8	72.7
	Enrollment (in thousands)											
All plans	12,203.5	100.0	2,883.5	100.0	1,807.1	100.0	1,638.3	100.0	4,195.8	100.0	149.7	100.0
Some provision for drugs	7,343.1	60.2	2,788.3	96.7	1,139.8	63.1	1,017.7	62.1	2,272.6	54.2	124.7	83.3
Own pharmacy	3,158.9	25.9	2,090.2	72.5	2.0	.1	915.7	55.9	137.6	3.3	13.4	9.0
Totally covered by prepayment	354.4	2.9	122.1	4.2	----	----	200.9	12.3	29.5	.7	1.9	1.3
Partially covered by prepayment	2,231.9	18.3	1,911.1	66.3	----	----	309.3	18.9	----	----	11.5	7.7
Not covered under prepayment but available at reduced cost	572.6	4.7	57.0	2.0	2.0	.1	405.5	24.8	108.1	2.6	----	----
No pharmacy	4,184.2	34.3	698.1	24.2	1,137.8	63.0	102.0	6.2	2,135.0	50.9	111.3	74.3
Totally covered by prepayment	58.8	.5	3.0	.1	4.0	.2	20.8	1.3	31.0	.7	----	----
Partially covered by prepayment	3,942.5	32.3	695.1	24.1	1,129.0	62.5	61.2	3.7	2,057.2	49.0	----	----
Not covered under prepayment but available at reduced cost	182.9	1.5	----	----	4.8	.3	20.0	1.2	46.8	1.1	111.3	74.3
No provision for drugs	4,860.4	39.8	95.2	3.3	667.3	36.9	620.6	37.9	1,923.2	45.8	25.0	16.7

[1] Table does not show figures for the three private group dental clinics and the 10 dental service corporation plans, none of which cover the item, but figures for these plans are included in the totals for all plans.

Of the 482 plans, 156, with an enrollment of 7,343,000, reported some provision for drugs; 326 plans, with an enrollment of 4,860,000, had no provision for drugs. The latter group included the three private dental clinics and the 10 dental service corporation plans (with a total enrollment of over 1½ million) which, of course, would have no interest in providing drugs for medical conditions. It is the larger plans that provide or furnish drugs on one basis or another; these plans have approximately 70 percent of the enrollment in all plans furnishing medical as opposed to dental benefits.

Of the 156 plans 131, with an enrollment of 6,588,000, were classified as providing drugs totally or partially on a prepayment basis and 35, with an enrollment of 756,000, were classified as not providing drugs under their prepayment program but making them available on a reduced charge basis, i.e., at prices somewhat below those of commercial (outside) pharmacies. The enrollment in the plans making drugs available (to some or all of their enrollees) on a prepayment basis is considerably in excess of the number of enrollees actually eligible for drugs on a prepayment basis as shown in tables 5, 6, and 7.[1] Much of the difference in the number of enrollees is due to the fact that tables 5, 6, and 7 showed only the number of persons actually covered for drugs on a prepayment basis while table 20 shows for a plan that had a prepayment drug program for any of its enrollees (who, perhaps, were a small minority), the whole membership of the plan. Since a plan that offers drugs on a prepayment basis to some of its subscribers is apt in a few years to have all of its enrollees on this basis, one may say that table 20 looks to the future and counts potential drug prepayment enrollment and not actual enrollment for drug benefits.

Of the 156 plans with some provision for drugs 63, with approximately 2.1 million enrollees, have their own pharmacy. Of these, 24, with an enrollment of 350,000, were classified as covering drugs totally under their prepayment program, i.e., covered persons make no direct payment for prescribed drugs or only a small one for each prescription. It will be realized that the enrollment in plans with their own pharmacy that furnish prescribed drugs to covered persons with no direct charge is quite small.[2]

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[1] These tables showed 121 plans providing drugs on a prepayment basis to 3,704,000 persons and 42 plans providing drugs on an "other basis" to 2,271,000 enrollees.

[2] Probably the best known plan which does this is Group Health Cooperative of Puget Sound, which had an enrollment of 111,000 at the end of 1968.

Another 18 plans, with 2.2 million participants, provide drugs partially on a prepayment basis. In some of the plans, the plan's pharmacy fills prescriptions for subscribers at charges distinctly below cost. In other cases, the plan's pharmacy fills prescriptions at charges slightly below those charged by outside pharmacies, but the members are reimbursed for, say, 80 percent of all expense incurred for drugs in excess of a certain amount, say, $50 per person in each year. Twenty-one plans that have pharmacies, with a total enrollment of 570,000, do not provide drugs under prepayment but make drugs available at reduced charges. Here the pharmacy fills prescriptions at charges about the same as or slightly less than the prices charged by outside pharmacies.

Ninety-three plans, with a total enrollment of 4.2 million persons, do not have a pharmacy but make some provision for drugs. About one-third of these plans—they have a quite small enrollment (59,000)—were classified as totally covering the cost of prescribed drugs under prepayment, i.e., drugs would be furnished with no direct charge or at only a minor, probably flat, charge per prescription. Fifty plans, with almost 4 million enrollees, partially covered drugs under their prepayment program, i.e., made drugs available at charges that were below cost or appreciably lower than charges at outside pharmacies. Fourteen plans, with an enrollment of close to 200,000, did not cover drugs under prepayment, but had arrangements for making them available at reduced charges, e.g., had arrangements with specified pharmacies in the area that agreed to fill prescriptions for covered persons at a discount.

The classifications used here—"totally covered by prepayment, partially covered . . ., not covered . . . but available at reduced cost"—are not neat, mutually exclusive categories; they overlap. It was often difficult to decide to which classification a plan should be assigned. The decision had to be based on the information provided by the plan, which in some cases was meager and subject to misinterpretation. The classification "totally covered by prepayment" includes a few plans where the enrollee paid a slight charge, say, $0.50 for each prescription. The classification "partially covered" includes those wherein the enrollee paid a direct charge for each prescription, but the charge was below the plan's costs, so that part of the cost of prescribed drugs was borne by the plan's subscription income. In general where "drugs were available at reduced prices," charges were at or above cost but lower than those charged by outside pharmacies.

The extent of provision for drugs varies considerably among the different types of plans. Of the 23 community group practice plans, 17, with 97 percent of the total enrollment, have some

provision for drugs. Fourteen plans, with 73 percent of the total enrollment, have their own pharmacy or pharmacies. (The plan's pharmacy is usually located off the lobby of the plan's clinic; if the plan has several clinics, each will have its own pharmacy.) Only four of the 14 plans that have their own pharmacy provide total prepayment coverage of drugs, i.e., furnish prescribed drugs to enrollees without any direct charges. These plans have only 5 percent of the enrollees in all community group practice plans that have pharmacies.

Of the plans that have their own pharmacy, seven plans, with the great predominance of the enrollees, provide drugs (to a significant share of their enrollees, if not to all) on a partial prepayment basis, i.e., where the member pays some direct charge. Generally the arrangement is that the plan's pharmacy fills prescriptions at prices that are below cost or significantly lower than those charged by other pharmacies. A few group practice plans that have pharmacies do not cover drugs under prepayment but make them available at reduced prices. These plans have a relatively small enrollment.

Three of the community group practice plans, with about 700,000 enrollees, do not have a pharmacy but nevertheless have some arrangements for coverage of drugs under prepayment, i.e., reimburse the subscriber for part of the charges incurred for prescribed drugs (probably over and above a deductible each year).

Of the 17 community individual practice plans only five—but they have over 60 percent of the total enrollment—have some provisions for drugs. Only one of these has a pharmacy. The great majority of the enrollment in plans making provision for drugs is in plans that partially cover the drug expense under prepayment. Generally the arrangement is of the major medical type, i.e., the plan will reimburse covered persons for, say, 80 percent of drug expense incurred in excess of a specified deductible.

Among the employer-employee-union group practice plans, over half, with over half of the enrollment, have some provision for drugs. Most of these plans, with almost all of the enrollment, have their own pharmacy. Of the enrollment in these latter plans, about 55 percent is in plans that totally or partially cover drugs under prepayment and 45 percent in plans that make drugs available at reduced costs, i.e., at charges lower than those of commercial pharmacies and at or below cost. Forty-four of the employer-employee-union group practice plans, with about 40 percent of the total enrollment have no provision for drugs.

Less than a quarter of the employer-employee-union individual practice plans have any provision for drugs. However, the plans that do are the larger ones and have over half the total enrollment.

A handful of the plans have their own pharmacy. This may seem anomalous, but it will be recalled that plans are classified on the basis of their main arrangement for providing service and that a plan could have a clinic even though it mainly provided medical service benefits by payments to private practitioners.

Three of the 11 private group clinics have some provision for drugs. They are the larger ones and have 83 percent of all enrollees in plans of this type. Only two of the smaller plans with 9 percent of the total enrollees, have their own pharmacy. The majority of the persons served by private group clinics—almost three-fourths—are in plans that do not have their own pharmacy but make drugs available at reduced charges.

EYEGLASSES

Of the 482 plans under consideration, 168—a little more than one-third, with one-third of all enrollees—have some provision for eyeglasses (see table 21). Excluding the dental clinic and dental service corporation plans, 46 percent of the total enrollment is in plans that make some provision for eyeglasses. Some 25 plans have their own optical unit or units. These have about three-fifths of the enrollment in all plans that make provision for eyeglasses.[3]

The majority of plans with their own optical unit do not cover eyeglasses on a prepayment basis but make them available at reduced charges, i.e., lower than the prices charged outside. These plans have 95 percent of the enrollment in plans with their own optical unit.

The 143 plans, with an enrollment of 1,500,000, that make provision for eyeglasses, but do not have their own optical unit, in most cases provide eyeglasses on a partial prepayment basis, that is, provide allowances toward the cost of an eye examination and eyeglasses that partly cover the cost. A few plans, with a relatively small enrollment, are shown as providing full coverage of the cost of eyeglasses under prepayment. These plans gave larger allowances toward the cost of eyeglasses. However, only infrequently would these allowances cover the full cost of eye examination and lenses and frames, and probably these plans should be included with those shown as partially covering the cost of eyeglasses.

[3] Again, the data from table 5 and table 21 do not correspond exactly, as indicated by the following:

Eyeglasses	Table 5		Table 21	
	Plans	Enrollment (in thousands)	Plans	Enrollment (in thousands)
Some provision for	166	3,673.7	168	4,061.1
Providing eyeglasses on prepayment basis	131	1,200.8	137	1,588.1
Providing eyeglasses on other basis	35	2,472.9	31	2,476.0

TABLE 21.—Arrangements for provision for eyeglasses [1]

Arrangements	All plans		Community group practice		Community individual practice		Employer-employee-union group practice		Employer-employee-union individual practice		Private group medical clinic	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
	Plans											
All plans	482	100.0	23	100.0	17	100.0	101	100.0	317	100.0	11	100.0
Some provision for eyeglasses	168	34.9	10	43.5	----	----	42	41.6	115	36.3	1	9.1
Own optical unit	25	5.2	8	34.8	----	----	15	14.9	1	.3	1	9.1
Totally covered by prepayment	2	.4	----	----	----	----	2	2.0	----	----	----	----
Partially covered by prepayment	9	1.9	1	4.3	----	----	8	7.9	----	----	----	----
Not covered under prepayment but available at reduced cost	14	2.9	7	30.4	----	----	5	5.0	1	.3	1	9.1
No optical unit	143	29.7	2	8.7	----	----	27	26.7	114	36.0	----	----
Totally covered by prepayment	25	5.2	1	4.3	----	----	4	4.0	20	6.3	----	----
Partially covered by prepayment	101	1.0	----	----	----	----	18	17.8	83	26.2	----	----
Not covered under prepayment but available at reduced cost	17	3.5	1	4.3	----	----	5	5.0	11	3.5	----	----
No provision for eyeglasses	314	65.1	13	56.5	17	100.0	59	58.4	202	63.7	10	90.9
	Enrollment (in thousands)											
All plans	12,203.5	100.0	2,883.5	100.0	1,807.1	100,0	1,638.3	100.0	4,195.8	100.0	149.7	100.0
Some provision for eyeglasses	4,064.1	33.3	2,119.4	73.5	----	----	845.6	51.6	987.8	23.5	111.3	74.3
Own optical unit	2,602.0	21.3	2,037.2	70.7	----	----	449.2	27.4	4.3	.1	111.3	74.3
Totally covered by prepayment	83.3	.7	----	----	----	----	83.3	5.1	----	----	----	----
Partially covered by prepayment	249.0	2.0	1.7	.1	----	----	247.3	15.1	----	----	----	----
Not covered under prepayment but available at reduced cost	2,269.7	18.6	2,035.5	70.6	----	----	118.6	7.2	4.3	.1	111.3	74.3
No optical unit	1,462.1	12.0	82.2	2.9	----	----	396.4	24.2	983.5	23.4	----	----
Totally covered by prepayment	366.4	3.0	5.5	.2	----	----	59.6	3.6	301.3	7.2	----	----
Partially covered by prepayment	889.4	7.3	----	----	----	----	268.6	16.4	620.8	14.8	----	----
Not covered under prepayment but available at reduced cost	206.3	1.7	76.7	2.7	----	----	68.2	4.2	61.4	1.5	----	----
No provision for eyeglasses	8,139.4	66.7	764.1	26.5	1,807.1	100.0	792.7	48.4	3,208.0	76.5	38.4	25.7

[1] Table does not show figures for the three private group dental clinic plans and the 10 dental service corporation plans, none of which cover this item, but figures for these plans are included in the totals for all plans.

Among the community group practice plans, 10 of the 23 have some provision for eyeglasses, and these 10 have three-quarters of the total membership. Almost all have their own optical unit. However, they generally do not cover the cost of eyeglasses under their prepayment program but simply make eyeglasses available at charges that are somewhat lower than those of outside opticians or optometrists. None of the community individual practice plans cover the cost of eyeglasses.

Forty-two of the 101 employer-employee-union group practice plans, with one-half the enrollment of all plans of this nature, have some provision for eyeglasses. Of the plans that make some provision, about a third, with one-half the enrollment, have their own optical unit. Most of these, with a majority of the enrollment, furnish eyeglasses on a partial prepayment basis, i.e., the clinic's optical unit provides glasses at charges that are equal to or below the optical unit's costs.

Among the employer-employee-union individual practice plans, one-third of the plans, with a little less than one-quarter of the enrollment, have some provision for eyeglasses. The great majority of these plans provide specified allowances toward charges incurred for lenses and frames. Many stipulate that such an allowance will be furnished not more than once a year for lenses and once every 2 years for frames. Again it is probably realistic to combine the plans shown as totally and partially covering eyeglasses under their prepayment program since rarely, if ever, would the specified allowances cover the full charges for eyeglasses. From the information furnished it was difficult to tell what share of the cost of eyeglasses would be covered by the eyeglasses benefit. The plans shown as totally covering eyeglasses under their prepayment plan provided larger allowances than the others.

It is of interest that a considerable number of the employer-employee-union plans that cover eyeglasses are those covering workers in occupations, such as truck drivers, for whom good eyesight is particularly desirable or necessary. One may judge that the benefit was included to encourage workers to have eye examinations periodically and to obtain needed eyeglasses.

Of the 11 private group medical clinic plans, only one makes some provision for eyeglasses. It has an optical unit and furnishes eyeglasses on a charge basis. This plan has 74 percent of the total number of persons served by these plans.

VII. CHANGES AND TRENDS, 1943-1968

THIS CHAPTER TRACES changes and trends in the number of plans, their enrollment, and their income and benefit expenditures as found by the surveys over the period 1943–1968.

The organizations dealt with are diverse. Their only common denominator is that they provide health care benefits on a prepayment or insurance basis and are not Blue Cross-Blue Shield plans or insurance companies. Changes in the number of plans, their enrollment, income, etc. not only reflect the establishment, growth, decline and demise of specified organizations but also the absorption of plans into Blue Cross-Blue Shield or the ranks of insurance companies or vice versa. A plan of this nature, which becomes a Blue Cross or Blue Shield plan, ceases to be one of these "other" plans. A plan which had been a Blue Cross or Blue Shield plan, but withdraws from that affiliation, joins the ranks of the plans under discussion.

Among employer-employee-union plans there is a considerable in and out movement of units which formerly self-insured for health care benefits but now take out insurance with Blue Cross-Blue Shield, an insurance company or other plans, or which had purchased insurance, but now undertakes to self-insure.

In considering the data set forth, it must also be borne in mind that at no time has the entire universe of plans of this nature been known. Hence, changes from survey to survey may reflect the extent of SSA's knowledge of all organizations coming within the scope of the survey and differences in the extent to which those contacted respond.

DATA FOR ALL PLANS

The first survey by ORS of these plans was made in 1943; since then surveys of all known plans have been made every 3 or 4 years.[1] Table 22 provides data on the number of plans and their enrollment for any benefit as found by the eight surveys over this

[1] As distinguished from the surveys made in intervening years of a sample of the larger plans; such sample surveys have been made since about 1957.

TABLE 22.—Number of plans and enrollment, 1943–1968

Year	All	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Medical society	Private group medical clinic	Private group dental clinic	Dental society
				Plans					
1943	214		[1] 44		[1] 113	33	24	----	----
1949	251		[1] 74		[1] 149	13	15	----	----
1953	304	26	54	104	100	6	14	----	----
1956	267		[1] 65		[1] 177	6	19	----	----
1959	267		[1] 63		[1] 175	6	23	----	----
1961	516	25	30	95	319	22	22	1	2
1964	582	28	15	147	360	2	18	3	9
1968	482	23	17	101	317	----	11	3	10
				Enrollment (in thousands)					
1943	3,320		[1] 462		[1] 1,425	942	491	----	----
1949	4,461		[1] 1,313		[1] 1,970	917	262	----	----
1953	9,524		[1] 4,202		[1] 4,223	902	197	----	----
1956	8,944	1,277	3,544	1,967	1,416	554	186	----	----
1959	9,876	1,453	3,718	2,227	1,611	618	249	----	----
1961	8,688	1,805	1,427	1,812	2,918	346	222	3	155
1964	10,025	2,178	1,300	1,593	4,119	10	250	26	549
1968	12,204	2,884	1,807	1,638	4,196	----	150	43	1,486

[1] Separate data for plans providing care through group practice not available.

period. The data presented differ from those presented in previous reports owing to changes in the classifications used, namely the breakdown of the community plans and employer-employee-union plans between those providing care through group or individual practice, respectively. The earlier surveys provided data on medical society plans; these ceased to be important and the grouping was discontinued. The data also differ from those presented in previous reports in that the Kaiser plans were included with the private group medical clinic plans in the 1949 through 1959 surveys, but are now included in all years under community group practice plans.

The number of plans of all types increased from 1943 to 1953, then dropped slightly in the 1956 and 1959 surveys, then increased greatly in the 1961 survey, still further increased in 1964, and dropped in this year's survey. The increase between 1959 and 1961 may be due to the fact that in 1961 a new source of information on all plans (a listing from the Department of Labor of self-insured employer-employee-union plans) enabled ORS to contact a larger number of plans than heretofore. The decrease by 100 in the number of plans from 1964 to 1968 seems to have been due mainly to the very considerable number of employer-employee-union organizations that formerly self-insured for one or more health benefits and by 1968 were purchasing insurance for all benefits.

The total enrollment in all plans increased irregularly from 3.3 million in 1943 to 12.2 million in 1968. A considerable part of the

increase from 1964 to 1968 is due to the new dental service corporation plans.

COMMUNITY GROUP PRACTICE PLANS

The earliest available separate data for the community group practice plans (these were formerly included with the individual practice plans in a combined grouping of community plans) is for the year 1953. There were 25 of these plans then. The number in 1968 is 23.[2] Over this 15-year period, a few small plans have gone out of existence;[3] and a few new plans have been established which may have considerable growth in the future.

Enrollment has grown from less than a million in 1953[4] to its present 2,884,000 (of which all but 64,000 is in the nine largest plans shown in appendix C). The growth in enrollment has been steady but, compared with Blue Cross, Blue Shield and insurance companies, slow.

COMMUNITY INDIVIDUAL PRACTICE PLANS

The number of community individual practice plans decreased from 54 in 1953 to 17 in 1968 and enrollment has substantially declined. Plans of this nature have gone out of existence, been absorbed by Blue Cross-Blue Shield, or become insurance companies. Virtually the entire growth in enrollment from 1964 to 1968 in these plans is due to the growth of Group Health Insurance, Inc. and its affiliate Group Health Dental Insurance.

This group of community individual practice plans includes three plans, with an aggregate enrollment of 26,000, which are sponsored by medical societies and would have been classified with medical society plans if that category had been continued. The group also includes six hospital service plans, with an enrollment of 308,000, some of which may in due course be absorbed by Blue Cross. The enrollment in the plans of this group was increased by almost a million in 1953 when Connecticut Blue Cross severed its affiliation with the Blue Cross Association and declined by 1.2 million in 1961 when the plan rejoined the Blue Cross Association.

EMPLOYER-EMPLOYEE-UNION GROUP PRACTICE PLANS

The number of these plans in 1968 is a few less than the number in 1953 and enrollment is down by over 300,000. The increase from 1961 to 1964 in the number of plans is due to the fact that in

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[2] See appendix C for data on enrollment and income of the nine largest community group practice plans in each year from 1950 to 1968.

[3] Including the Elk City, Oklahoma, plan which was an important pioneer.

[4] Precise figures not available, but the nine largest had an enrollment of 850,000 in 1953.

the 1964 survey some 25 units of the International Ladies Garment Workers Union in New York City that purchased care for their members from the Union Health Center were shown as providing care through group practice. In the 1961 survey only the Union Health Center was shown as providing care through group practice. The 1968 survey reverted to the earlier practice and shows the different locals as purchasing care on a prepayment basis from the Union Health Center, and only the latter organization being considered a group practice plan.

The principal employer-employee-union organizations that provide care through group practice are of three types: (1) unions or union welfare funds that maintain union or labor health centers, which provide to the members physician care (some only diagnostic services) only at the center; (2) the railway employee hospital associations, and (3) the relatively small number of unions or union welfare funds that have established programs providing comprehensive health care to union members and their dependents. Included among the latter are the St. Louis Labor Health Institute, the Union Family Medical Fund of the Hotel Industry of New York City, and the Union Health Service, Inc. of Chicago.[5]

The union health centers which provide care only at the center no longer seem particularly attractive to union members; some of the present centers show signs of stagnation and few new centers of this type have been established in recent years. The railway employee hospital associations, serving only the employees and not dependents, and providing care only at designated points along the line, and with falling railway employment, are showing signs of decline. Those unions which desire for their members programs providing comprehensive health care through group practice have concluded that, rather than establish a plan just for their members, it is better to cooperate with other unions in the establishment of a community prepaid group practice plan. All these factors are likely to result in a continuation of the decline in number of persons served by employer-employee-union group practice plans.

EMPLOYER-EMPLOYEE-UNION INDIVIDUAL PRACTICE PLANS

These plans increased both in number and enrollment in the various surveys up to 1964; the 1968 survey indicates a decline in the number of plans but enrollment continuing at about the 1964 level.

There is a constant in and out movement among this group, i.e., employers, unions or welfare funds that formerly had insured

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[5] The members of all the cited plans have hospital coverage, but this is provided through insurance with Blue Cross or an insurance company.

health plans are turning to self-insurance, or those that formerly self-insured are turning to insurance.

There were 113 organizations included in the 1965 survey that reported in 1969 that they no longer came within the terms of the survey. The majority of these were employers, union welfare funds, or employee benefit associations that had formerly self-insured for one or more health care benefits, and which since have purchased insurance for these benefits. Some replies indicated disenchantment with self-insurance as a means of holding in check the cost of health benefits. (Several replies indicated that one of the advantages of insurance—as opposed to self-insurance—was that increases in cost could not be attributed to faulty management.) A considerable number of welfare funds purchase insurance for the more standard type of health coverage, i.e., hospital, surgical, and in-hospital benefits, but self-insure for newer more experimental benefits such as physician office visits, drugs, and dental care.

The pros and cons of self-insurance or insurance for health benefits are many and need not be gone into here. The returns of this year's survey suggest a trend away from self-insurance and toward purchase of health benefit coverage from a carrier, including the community group practice plans. Whether this trend will continue remains to be seen.

MEDICAL SOCIETY PLANS

Over the years these plans have declined in number and enrollment as they became Blue Shield plans. The large increase in 1961 was due to the fact that that survey reported some 15 separate plans in the State of Washington that formerly had been considered a single plan. By 1964, the number of medical society plans and their enrollment had so diminished that it was decided to not retain the category any longer. Three plans of this nature, with an enrollment of about 23,000, are included among the community individual practice plans.

PRIVATE GROUP MEDICAL CLINIC PLANS

The 1943 survey found 24 of these plans with an enrollment of about half a million. Since then the number of plans and the people covered has shown a declining trend. In 1968 the number of plans declined to 11 and enrollment to 150,000. Several clinics included in the 1964 survey reported that they had discontinued their prepayment program.

The figures previously published (in the 1965 and 1961 survey reports) for these plans were inflated because the 1953, 1956, and 1959 data included the Kaiser plans (considered as a single organ-

ization). In the 1961 survey it was decided to classify these plans as community group practice plans and the same practice has been followed since. However, the figures for the earlier years had not been revised to reflect this change.

Whether decline in the number and enrollment of private group medical clinic plans will continue is a matter for conjecture. The American Association of Medical Clinics (with over 240 member clinics—a clinic must have at least 5 physicians to be eligible) had a session on clinic prepayment programs at its 1969 convention. At its close the chairman asked how many clinics represented had a prepayment plan and how many were thinking of establishing such a plan. Only a few hands were raised in response to each question.

PRIVATE GROUP DENTAL CLINICS

This group for the first time was broken out as a separate category in the 1968 survey. There were about the same number of clinics with about the same enrollment as in 1964.

DENTAL SERVICE CORPORATION PLANS

The number of these plans and their enrollment has been increasing. Much of the increased enrollment is due to the growth of just two or three plans. It is not yet clear whether dental service corporation plans sponsored by dental societies will be a main carrier of dental insurance; whether dentists will wish to establish and back their own plans; or whether dental insurance will be provided mainly by Blue Cross-Blue Shield and insurance companies.

TRENDS IN ENROLLMENT FOR SPECIFIED BENEFITS

Table 23 shows the number of persons covered for specified benefits over the period 1943–68. It will be seen that enrollment for hospital care has risen gradually from 2,400,000 in 1943 to 7,300,000 in 1968. Enrollment of the community group practice plans for hospital care rose from 714,000 in 1956, the earliest year for which figures are available, to 2,100,000 in 1968. Enrollment for hospital care of the community individual practice plans and the employer-employee-union group practice plans has declined; that of the employer-employee-union individual practice has risen although the increase from 1964 to 1968 was very small. The number of people covered for hospital care by the private group medical clinics has diminished to insignificance.

Enrollment for surgery follows a similar general trend but at a higher level due to the fact that two large plans, Group Health

TABLE 23.—Enrollment for specified benefits, 1943–1968

[In thousands]

Year	All	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Medical society	Private group medical clinic	Private group dental clinic	Dental society[1]
Hospital									
1943	2,441	386		1,320		290	445	----	
1949	3,868	956		1,868		756	288	----	
1953	7,134	2,864		3,541		654	75	----	
1956	6,079	714	2,242	1,695	1,371	38	19	----	
1959	6,086	862	1,985	1,620	1,533	42	44	----	
1961	6,134	1,109	519	1,437	2,684	344	41	----	
1964	6,840	1,455	404	1,052	3,733	8	188	----	
1968	7,277	2,103	404	920	3,829	----	20	----	
Surgical									
1943	3,092	448		1,238		939	467	----	
1949	3,293	848		1,470		663	312	----	
1953	6,999	2,408		3,516		902	173	----	
1956	6,906	1,274	1,878	1,743	1,297	554	160	----	
1959	7,494	1,427	2,117	1,659	1,479	618	194	----	
1961	7,564	1,797	1,008	1,476	2,726	346	211	----	
1964	8,297	2,146	965	1,150	3,818	10	208	----	
1968	8,752	2,874	1,258	1,034	3,442	----	143	----	
In-hospital medical									
1943	3,115	448		1,234		942	491	----	
1949	2,870	682		1,233		643	312	----	
1953	5,757	1,654		3,018		888	197	----	
1956	6,125	1,271	1,179	1,942	999	548	186	----	
1959	6,786	1,426	1,727	1,760	1,041	618	214	----	
1961	7,227	1,795	914	1,492	2,463	346	217	----	
1964	7,425	2,147	953	783	3,286	10	246	----	
1968	8,492	2,873	1,260	714	3,503	----	143	----	
Office and clinic									
1943	2,413	426		1,259		303	425	----	
1949	3,146	684		1,507		643	312	----	
1953	3,674	1,103		1,824		550	197	----	
1956	5,194	1,270	466	1,940	807	526	185	----	
1959	5,702	1,425	881	2,021	1,085	42	248	----	
1961[2]	6,889	1,786	662	1,635	2,243	341	222	----	
1964	6,512	2,163	725	1,447	1,938	5	234	----	
1968	7,797	2,884	1,130	1,375	2,264	----	143	----	
Dental									
1943	1,793	314		959		189	331	----	
1949	NA	NA	NA	NA	NA	NA	NA	----	
1953	642	207		435		----	----	----	
1956	334	65	8	183	78	----	----	----	
1959	500	32	22	281	160	----	5	----	
1961	953	71	118	324	282	----	----	3	155
1964	1,801	3	97	409	717	----	----	26	549
1968	2,750	----	304	475	442	----	----	43	1,486
Drugs									
1943	NA	NA	NA	NA	NA	NA	NA	----	
1949	NA	NA	NA	NA	NA	NA	NA	----	
1953	NA	NA	NA	NA	NA	NA	NA	----	
1956	NA	NA	NA	NA	NA	NA	NA	----	
1959	NA	NA	NA	NA	NA	NA	NA	----	
1961	1,301	108	15	390	764	4	20	----	
1964	2,659	179	10	691	1,757	3	19	----	
1968	5,975	2,383	422	995	2,062	----	114	----	

NA Not available.

[1] Includes home calls.

Insurance and the Health Insurance Plan of Greater New York, do not cover hospital care or at any rate cover it for an insignificant enrollment. The enrollment for surgery of community group practice plans more than doubled from 1956 to 1968, rising from 1,300,000 to 2,900,000. The enrollment for this service of the community individual practice plans dropped by about half from 1956 to 1964. The increase from 1964 to 1968 reflects the increase in the enrollment of Group Health Insurance, Inc. The enrollment of employee-union group practice plans has steadily declined. That of the employer-employee-union individual practice plans steadily and substantially increased, reaching a peak of 3.8 million in 1964 and then declining to 3.4 million in 1968. The number of persons covered for this service by the private group medical clinic plans waxed and waned over this period and declined to a low of 143,000 in 1968.

The trends for coverage of in-hospital medical visits are about the same.

Aggregate enrollment of all plans for physician office and clinic visits follows a course similar to that for surgery and in-hospital visits. The course of enrollment of the community group practice plans for this service is, as might be expected, about the same as for surgery and in-hospital visits. Enrollment of the community individual practice plans for office and clinic visits has gradually increased over the period to a high of 1.1 million in 1968; the figures largely reflect Group Health Insurance's increased enrollment for this service. The number of persons covered by the employer-employee-union group practice plans for this service has gradually declined from 1.9 million in 1956 and 2.0 million in 1959 to 1.4 million in 1968. The enrollment of the employer-employee-union individual practice plans for this service has been about the same level during the past three surveys—2.3 million in 1968. The enrollment of the private group medical clinic plans follows the same trend as for surgery.

The number of persons covered by all plans for dental care has increased from 334,000 in 1956 to 2,750,000 in 1968. The increase shown by the community individual practice plans reflects the figures for Group Health Dental Insurance. Enrollment for dental care of the employer-employee-union group practice plans has slowly but measurably increased. That among the employer-employee-union individual practice plans reached a high of 700,000 in 1964 and then dropped to 440,000 in 1968. Enrollment of the private group dental clinic plans and dental service corporations has measurably increased.

Data on enrollment for drug benefits has been available only for 1961 and subsequent years. The figures for all plans show a sub-

stantial increase in the number of persons covered, from 1.3 million in 1961 to 6.0 million in 1968. Much of this increase is in the community group practice plans, but the community individual practice plans, the employer-employee-union group practice, and individual practice plans and the private group medical clinic plans all show an increase in enrollment for this service.

INCOME AND BENEFIT EXPENDITURES

The aggregate income of all the plans increased from $94 million in 1949 to $778 million in 1968. The income of the community group practice plans has increased from about $14 million in 1950 (see appendix C) to $248 million in 1968. That of the community individual practice plans declined from $79 million in 1959 (figures for earlier years not available) to $41 million in 1961 and increased to $70 million in 1968. The income of the employer-employee-union group practice plans has remained about the same over the last 9 years; that of the employer-employee-union individual practice plans has quadrupled. The income of the private group medical clinic plans has increased from $9 million in 1959 to $12 million in 1968. The income of the dental society plans has increased from $1 million to $3.7 million. Benefit expenditures, as might be expected, show similar trends.

TABLE 24.—Income and benefit expenditures, 1943–1968

[In millions]

Year	All	Community group practice	Community individual practice	Employer-employee-union group practice	Employer-employee-union individual practice	Medical society	Private group medical clinic	Private group dental clinic	Dental society
	Income								
1943	NA	NA	NA	NA	NA	NA	NA	----	
1949	$94	$21		$43		$22	$8	----	
1953	230	77		129		14	10	----	
1956	290	116		153		16	5	----	
1959	337	$71	$79	$102	$67	9	9	----	
1961	394	103	41	102	118	19	10	(1)	$1
1964	546	147	49	95	232	1	10	1	11
1968	778	248	70	108	302	----	12	1	37
	Benefit expenditures								
1943	NA	NA	NA	NA	NA	NA	NA	----	
1949	$82	$16		$40		$19	$7	----	
1953	218	73		125		11	9	----	
1956	254	102		132		14	5	----	
1959	318	$67	$71	$100	$63	9	8	----	
1961	362	96	37	97	107	16	8	(1)	$1
1964	495	136	41	83	213	1	10	$1	10
1968	759	250	70	106	287	----	12	1	33

NA Not available.
[1] Less than $500,000.

ENROLLMENT AND FINANCIAL EXPERIENCE OF GROUP PRACTICE PLANS

Tables 25 and 26 summarize changes and trends for the plans that provide care through group practice, i.e., the community

TABLE 25.—Group practice plans: Enrollment for specified benefits, 1943–1968

[In thousands]

Year	All	Community group practice	Employer-employee-union group practice	Private group medical clinic	Private group dental clinic
			Hospital		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	1,802	NA	NA	NA	----------
1956	2,428	714	1,695	19	----------
1959	2,526	862	1,620	44	----------
1961	2,587	1,109	1,437	41	----------
1964	2,695	1,455	1,052	188	----------
1968	3,043	2,103	920	20	----------
			Surgical		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	2,410	NA	NA	NA	----------
1956	3,177	1,274	1,743	160	----------
1959	3,280	1,427	1,659	194	----------
1961	3,484	1,797	1,476	211	----------
1964	3,504	2,146	1,150	208	----------
1968	4,051	2,874	1,034	143	----------
			In-hospital medical		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	2,507	NA	NA	NA	----------
1956	3,399	1,271	1,942	186	----------
1959	3,400	1,426	1,760	214	----------
1961	3,504	1,795	1,492	217	----------
1964	3,176	2,147	783	246	----------
1968	3,720	2,873	714	143	----------
			Office and clinic		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	2,853	NA	NA	NA	----------
1956	3,395	1,270	1,940	185	----------
1959	3,694	1,425	2,021	248	----------
1961	3,643	1,786	1,635	222	----------
1964	3,844	2,163	1,447	234	----------
1968	4,402	2,884	1,375	143	----------
			Dental		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	452	NA	NA	NA	----------
1956	248	65	183	----------	----------
1959	318	32	281	5	----------
1961	398	71	324	----------	3
1964	438	3	409	----------	26
1968	518	----------	475	----------	43
			Drugs		
1943	NA	NA	NA	NA	----------
1949	NA	NA	NA	NA	----------
1953	NA	NA	NA	NA	----------
1956	NA	NA	NA	NA	----------
1959	NA	NA	NA	NA	----------
1961	518	108	390	20	----------
1964	889	179	691	19	----------
1968	3,492	2,383	995	114	--------

NA Not available.

TABLE 26.—Group practice plans: Income and benefit expenditures, 1943–1968

[In millions]

Year	All	Community group practice	Employer-employee-union group practice	Private group medical clinic	Private group dental clinic
	Income				
1943	NA	NA	NA	NA	----
1949	NA	NA	NA	NA	----
1953	$75	$15	$50	$10	----
1956 [1]	136	42	89	5	----
1959	182	71	102	9	----
1961	215	103	102	10	(2)
1964	253	147	95	10	$1
1968	369	248	108	12	1
	Benefit expenditures				
1943	NA	NA	NA	NA	----
1949	NA	NA	NA	NA	----
1953	$66	$14	$43	$9	----
1956 [1]	122	40	77	5	----
1959	175	67	100	8	----
1961	202	97	97	8	(2)
1964	230	136	83	10	$1
1968	368	250	105	12	1

NA Not available.
[1] Estimated.
[2] Less than $500,000.

group practice plans, the employer-employee-union group practice plans, the private group medical clinic plans, and the private group dental clinic plans.

Enrollment for hospital benefits in all of the group practice plans increased from 1.8 million in 1953 to 3.0 million in 1968. For surgery, the increase was from 2.4 million in 1953 to 4.0 million in 1968, and for office and clinic visit coverage from 2.9 million to 4.4 million. About three-fourths of the enrollment in all group practice plans are in the community plans.

Employer-employee-union plans are the biggest providers of dental care under group practice arrangements, having 475,000 persons covered as against 43,000 for the private group dental clinics.

The income of all plans providing care mainly through group practice increased from $75 million in 1953 to $369 million in 1968. Benefit expenditures increased from $66 million to $368 million.

The shares of the different types of plans in the total have changed. In 1953 the employer-employee-union plans received two-thirds of the income of all group practice plans and the community plans 20 percent. These proportions were reversed in 1968, with the community plans receiving two-thirds of the total and the employer-employee-union plans, 29 percent. The share of the private group medical clinics has progressively diminished.

APPENDIX A

Directory of Plans by Type and State

This directory lists 504 health insurance plans other than Blue Cross or Blue Shield plans or insurance companies that were known to ORS in January 1970. The organizations are listed according to the type of plan and the State.

The number of listed plans of each type is as follows:

Community group practice—26
Community individual practice—18
Employer-employee-union group practice—102
Employer-employee-union individual practice—325
Private group medical clinic—13
Private group dental clinic—3
Dental service corporations—17

The symbols after the name of the plan indicate the following:

* Provides medical service through group practice

\# Provides dental service through group practice

@ Plan not included in 1969 survey tabulations because it commenced operation since survey, or for other reasons

The letters and numbers below the name and address of the plan indicate the services covered or provided by the plan, i.e., services the plan itself underwrites or for which it self-insures. The health care benefits are coded as follows:

A. Hospital care

B. Physician service
   1. Surgical
   2. In-hospital visits
   3. X-ray and laboratory
   4. Office visits
   5. Home visits

C. Dental care

D. Drugs (provided on prepayment basis)

E. Vision care (eye refraction examinations and/or eyeglasses)

CALIFORNIA

Family Health Program of So. Calif.*
2925 N. Palo Verde Avenue
Long Beach, California 90815
A, B 1 2 3 4 5

Harkness Health Plan* @
1400 Fell Street
San Francisco, California 94117
A, B 1 2 3 4 5, D, E

Kaiser Foundation Health Plan, Inc.*
Northern California Region
1924 Broadway
Oakland, California 94612
A, B 1 2 3 4 5, D, E

Kaiser Foundation Health Plan, Inc.*
Southern California Region
4900 Sunset Boulevard
Los Angeles, California 90027
A, B 1 2 3 4 5, D, E

Physicians and Surgeons Assn.*
17100 Ventura Boulevard
Encino, California 91316
B 1 2 3 4, E

Transportation Hospital Assn.*
610 South Main Street
Los Angeles, California 90014
A, B 1 2 3 4, E

COLORADO

Kaiser Foundation Health Plan* @
204 Franklin
Denver, Colorado 80218
A, B 1 2 3 4 5, E

DISTRICT OF COLUMBIA

Group Health Association, Inc.*[1]
2121 Pennsylvania Avenue, N.W.
Washington, D.C. 20037
B 1 2 3 4 5, D, E

FLORIDA

La Benefica Espanola*
2011½ - 15th Street
P.O. Box 5265
Tampa, Florida 33605
A, B 3 4 5, D

Circulo Cubano de Tampa*
14th Street and Tenth Avenue
P.O. Box 5625
Tampa, Florida 33605
A, B 1 2 3 4 5, D, E

HAWAII

Kaiser Foundation Health Plan, Inc.*
Hawaii Region
1697 Ala Moana Boulevard
Honolulu, Hawaii
A, B 1 2 3 4 5, D, E

MARYLAND

East Point Medical Center*
1012 Old North Pt. Road
Baltimore, Maryland 21224
B 1 2 3 4

MASSACUSETTS

Harvard Community Health Plan*@
690 Beacon Street
Boston, Massachusetts 02215
A, B 1 2 3 4 5, E

MICHIGAN

Community Health Association*
13936 Woodward Avenue
Highland Park, Michigan 48203
A, B 1 2 3 4 5, E

MINNESOTA

Community Health Center, Inc.*
4th Street at 11th Avenue
Two Harbors, Minnesota 55616
A, B 1 2 3 4 5, D, E

Group Health Plan, Inc.*
2500 Como Avenue
St. Paul, Minnesota 55108
A, B 1 2 3 4 5, E

NEW JERSEY

Luso American Fraternal Assn.*
214 Walnut Street
Newark, New Jersey 07105
A, B 1 2 4 5

NEW YORK

Health Insurance Plan of Greater New York*
625 Madison Avenue
New York, New York 10022
B 1 2 3 4 5, D, E

OHIO

Kaiser Community Health Foundation*
1600 Illuminating Building
55 Public Square
Cleveland, Ohio 44113
A, B 1 2 3 4 5, E

The Medical Foundation of Bellaire*
4211 Noble Street
Bellaire, Ohio 43906
A, B 1 2 3 4 5, E

OKLAHOMA

Northwest Community Hospital Assn.*
Box 7
Mooreland, Oklahoma 73852
A, B 1 2 3 4 5, D

[1] Covers hospital care but uses D.C. Blue Cross plan to pay hospitals.

OREGON

Kaiser Foundation Health Plan, Inc.*
(Oregon Region)
1618 S.W. First Avenue
Portland, Oregon 97201
A, B 1 2 3 4 5, D, E

TEXAS

Laura Eldridge Hospital Association*
Box 167
Sugar Land, Texas 77478
A, B 1 2 3 4, D

VIRGINIA

Southwest Virginia Community Health Service, Inc.*
Clintwood, Virginia 24228 and
Wise Virginia 24093
B 3 4, D

WASHINGTON

Group Health Cooperative of Puget Sound*
200 15th Avenue E.
Seattle, Washington 98102
A, B 1 2 3 4 5, D, E

Tri-County Health Care Assn.*
Box 547
Deer Park, Washington 99006
A, B 1 2 3 4

COMMUNITY INDIVIDUAL PRACTICE PLANS

CALIFORNIA

Academic Mutual Aid Health Plan
P.O. Box 24451
Los Angeles, California 90024
A, B 1 2 3 4

Blue Crest Medical Plan
6715 Hollywood Boulevard
Suite 200
Hollywood, California 90028
B 1 3 4 5

California Vision Services @
1330 21st Street
Sacramento, California 95814
E

Foundation for Medical Care of San Joaquin County
445 West Acacia Street
P.O. Box 230
Stockton, California 95203
B 1 2 3 4 5

COLORADO

Hospital Service, Inc.
P. O. Box 548
Ft. Collins, Colorado 80521
A, B 1 2 3 4

FLORIDA

Centro Asturiano de Tampa, Inc.
Formerly Delegacion del Centro Asturiano de la Habana
1913 Kathleen Street
P.O. Box 984
Tampa, Florida 33601
A

L'Unione Italiana, Inc.
1725½ - 1731 East Broadway
Tampa, Florida 33605
A, B 2 3 4, C

GEORGIA

Griffin Hospital Care Assn., Inc.
P.O. Box 363
Griffin, Georgia 30223
A

NEW JERSEY

Garden State Hospitalization Plan
214 Smith Street
Perth Amboy, New Jersey 08861
A

NEW YORK

Group Health Dental Insurance, Inc.
227 West 40th Street
New York, New York 10018
C

Group Health Insurance, Inc.
227 West 40th Street
New York, New York 10018
B 1 2 3 4 5, D

Spanish Benevolent Society, Inc.
"La Nacional"
239 West 14th Street
New York, New York 10011
A, B 1 2 3 4, D, E

OHIO

Hospital Service Association of Licking County, Inc.
603 Trust Building
Newark, Ohio 43055
A

OREGON

National Hospital Association
1501 Southwest Taylor Street
Portland, Oregon 97205
A, B 1 2 3 4 5

Physicians Association of Clackamas County
P.O. Box 286
Gladstone, Oregon 97027
A, B 1 2 3, C, D

PENNSYLVANIA

Inter-County Hospitalization Plan Inc.
Foxcroft Square
Jenkintown, Pennsylvania 19046
A

TEXAS

Dallas County Medical Plan
433 Medical Arts Building
Dallas, Texas 75201
B 1 2 3 4 5, E

WEST VIRGINIA

Morgantown Hospital Service, Inc.
265 High Street
Morgantown, West Virginia 26505
A

EMPLOYER-EMPLOYEE-UNION GROUP PRACTICE PLANS

ALABAMA

American Cast Iron Pipe Co.*
Mutual Benefit Association
P.O. Box 2603
Birmingham, Alabama 35202
A, B 1 2 3 4, C, E

ARIZONA

Inspiration Consolidated Copper Company*
Inspiration Employees Benefit Fund
Inspiration, Arizona 85537
A, B 1 2 3 4 5, D

Phelps Dodge Corporation*
Hospital-Medical-Surgical Plan
(Western Operation)
P.O. Box 1238
Douglas, Arizona 85607
A, B 1 2 3 4 5, D, E

ARKANAS

Dierks Forest, Inc.*
Dierks Employees Medical and Hospital Association
810 Whttington Avenue
Hot Springs, Arkansas 71901
A, B 1 2 3 4

CALIFORNIA

Culinary Workers and Bartenders Welfare Fund*#
Long Beach and Orange County
246 E. 4th Street
Long Beach, California 90812
B 1 2 3 4 5, C, E

Culinary Welfare Fund, Santa Monica*#
411 W.M. Garland Building
117 West Ninth Street
Los Angeles, California 90015
A, B 1 2 3 4 5, C, E

Ladies' Garment Workers (ILGWU)*
Los Angeles Cloak
Los Angeles, California
A, B 1 3 4, E

Ladies' Garment Workers (ILGWU)*
Los Angeles Dress and Sportswear
Los Angeles, California
A, B 1 3 4, E

Los Angeles Hotel and Restaurant#
Union Welfare Fund
130 So. Alvarado Street
Los Angeles, California 90057
C

Retail Clerks Local 770 and Food Employers Benefit Fund#
1515 North Vermont Avenue
Los Angeles, California 90027
A, B 1 2 3 4 5, C, D, E

Santa Monica Restaurant and Hotel Assn.*#
411 W.M. Garland Building
117 West Ninth Street
Los Angeles, California 90015
B 1 2 3 4 5, C, E

Southern Pacific Employees Hospital Association*
1400 Fell Street
San Francisco, California 94117
A, B 1 2 3 4 5, E

COLORADO

Gates Mutual Benefit Club*#
1000 So. Broadway
Denver, Colorado 80217
A, B 1 2 3 4 5, C, D, E

Public Service Co. of Colorado
Employees Mutual Aid Association
550 - 15th Street
Denver, Colorado 80202
A, B 1 2 3 4 5, D, E

DELAWARE

Electra Arms Medical Center*
1800 North Broom Street
Wilmington, Delaware 19802
B 4, E

GEORGIA

Ladies' Garment Workers (ILGWU)*
Southeast Region
Atlanta, Georgia
A, B 1 3 4, E

Utilities Employees Assn.*
125 Pine Street, N.E.
Atlanta, Georgia 30308
A, B 1 3 4 5, D, E

HAWAII

East Maui Irrigation Company*
Medical Plan
P.O. Box 196
Paia, Maui, Hawaii 96779
A, B 1 2 3 4, D

Grove Farm Company, Inc.*
Medical Plan
Puhi Rural Station
Lihue, Hawaii 96766
A, B 1 2 3 4 5, D

Hamakua Mill Company*
Medical Plan
P.O. Box 158
Paauilo, Hawaii 96776
A, B 1 2 3 4, D

HAWAII—Continued

Hawaiian Agricultural Company*
Medical Plan
Pahala, Hawaii 96777
A, B 1 2 3 4, D

Hawaiian Commercial and Sugar Co.*
A Division of Alexander and Baldwin, Inc.
P.O. Box 258
Puunene, Hawaii 96784
A, B 1 2 3 4, D

Honokaa Sugar Company*
B.U. Medical Plan
Haina, Hawaii 96709
A, B 1 2 3 4, D

Hutchinson Sugar Company, Ltd.*
Salaried Medical Plan
Naalehu, Hawaii 96772
A, B 3 4 5

Kahuku Plantation Co. Medical Plan*
P.O. Box 278
Kahuku, Hawaii 96731
A, B 1 2 3 4 5, D

Laupahoehoe Sugar Company* Medical Plan*
P.O. Box 278
Papaaloa, Hawaii 96780
A, B 1 2 3 4 5, D

The Lihue Plantation Co. Ltd.*
Medical Plan
P.O. Box 751
Lihue, Hawaii 96766
A, B 1 2 4, D

Mauna Kea Sugar Company, Inc.*
528 Wainaku Street
Hilo, Hawaii 96720
A, B 1 2 3 4 5, D

Oahu Sugar Company, Ltd.*
Medical Plan
P.O. Box 0
Waipahu, Hawaii 96797
A, B 1 2 3 4, D

Paauhau Sugar Company, Ltd.*
Paauhau, Hawaii 96775
A, B 1 2 3 4, D

Pepeekeo Sugar Company*
Pepeekeo, Hawaii 96783
A, B 1 2 3 4 5, D

Pioneer Mill Company, Ltd.*
Medical Plan
P.O. Box 727
Lahaina, Maui, Hawaii 96761
A, B 1 2 3 4 5, D

Puna Sugar Company, Limited*
Keaau, Hawaii 96749
A, B 1 2 3 4 5, D

Wailuku Sugar Company*
1644 Mill Street
Wailuku, Maui, Hawaii 96793
A, B 1 2 3 4 5, D

ILLINOIS

Beef Boners and Sausage Makers*
Union Locals 100 and 485
Union Medical Center
1657 West Adams Street
Chicago, Illinois 60612
B 3 4, D, E

Hatters, Cap and Millinery Workers*
Local 52 Health Fund
407 South Dearborn Street
Chicago, Illinois 60604
A, B 4

Illinois Central Hospital Assn.*
5800 Stony Island Avenue
Chicago, Illinois 60637
A, B 1 2 3 4 5

Ladies' Garment Workers (ILGWU)*
Chicago Health Center Trust
15 South Wacker Drive
Chicago, Illinois 60606
B 3 4

Ladies' Garment Workers (ILGWU)*
Chicago and Midwest Dressmakers
15 South Wacker Drive
Chicago, Illinois 60606
A, B 1, E

Union Health Service, Inc.*
1634 West Polk Street
Chicago, Illinois 60612
B 1 2 3 4 5, E

Wabash Memorial Hospital Assn.*
360 E. Grand Avenue
Decatur, Illinois 62525
A, B 1 2 3 4 5, D, E

LOUISIANA

Stanocola Medical Association*
1401 North Foster Dr.
Baton Rouge, Louisiana 70805
B 1 2 3 4 5, E

MARYLAND

The Baltimore Transit Co.*#
Welfare Program
1515 Washington Boulevard
Baltimore, Maryland 21230
A, B 1 2 3 4 5, C, E

Ladies' Garment Workers (ILGWU)*
Upper South
1 North Howard Street
Baltimore, Maryland 21228
A, B 1 3 4, E

MASSACHUSETTS

Ladies' Garment Workers (ILGWU)*
Boston Joint Board
33 Harrison Avenue
Boston, Massachusetts 02111
A, B 1 3 4, E

MASSACHUSETTS—Continued

Teamsters, Local 25*#
Health and Welfare Fund
544 Main Street
Boston, Massachusetts 02129
C, E

MINNESOTA

Northern Pacific Beneficial Assn.*
629 Northern Pacific Building
St. Paul, Minnesota 55101
A, B 1 2 3 4 5, D, E

MISSISSIPPI

Delta and Pine Land Company*
Employee's Hospital and Surgical Cooperative Program
Scott, Mississippi 38772
A, B 1 2

MISSOURI

Ladies' Garment Workers (ILGWU)*
Central States Health and Welfare Fund
110 North Ninth Street
St. Louis, Missouri 63108
A, B 1 3 4

Meatcutters, Local 88*
Medical Institute
Welfare Fund Trust
4488 Forest Park Avenue
St. Louis, Missouri 63108
B 1 2 3 4, C

Missouri Pacific Employees' Hospital Association*#
1755 S. Grand
St. Louis, Missouri 63104
A, B 1 2 3 4 5

St. Louis Labor Health Institute*#
1641 South Kingshighway
St. Louis, Missouri 63110
B 1 2 3 4 5, C, E

Textile Workers Union#
St. Louis Joint Board
St. Louis Employers - TWU Benefit Program
1601 South Broadway
St. Louis, Missouri 63104
C, E

Transit Services Corp. of Metropolitan St. Louis*
Employees Mutual Benefit Association
3903 Park Avenue
St. Louis, Missouri 63110
A, B 1 2 3 4 5, E

NEW JERSEY

Ladies' Garment Workers (ILGWU)*
So. Jersey-Philadelphia Cloak
453 Lansdowne Avenue
Camden, New Jersey 08104
A, B 1 3 4, D, E

NEW YORK

Bartenders Union and United R.L.D.*#
Trust Fund
30 East 29th Street
New York, New York 10016
A, B 1 2 3 4, C, E

Bedding, Curtain and Drapery Workers*
Local 140 UFWA AFL-CIO
Security Fund
80 East 11th Street
New York, New York 10003
A, B 1 2 3 4 5, E

Building Service Employees*
Local 32J Welfare Fund
Diagnostic Clinic
237 East 36th Street
New York, New York 10016
B 3 4

Doll and Toy Workers, Local 139*#
Sick and Welfare Fund
59-26 Woodside Avenue
Woodside, New York 11377
B 3 4, C, E

Electrical Industry*#
Pension, Hospitalization and Benefit Plan
158-11 Jewel Avenue
Flushing, New York 11315
A, B 1 3 4, C, E

Electrical Wholesalers Industry Local 3 (IBEW)*#
Employees Security Fund
158-11 Jewel Avenue
Flushing, New York 11365
A, B 1, C, E

Electrical Workers, Local 3 (IBEW)*#
Employees Security Fund
158-11 Jewel Avenue
Flushing, New York 11365
A, B 1, C

Electrical Manufacturing Industry, Local 3 (IBEW)*#
Employees Retirement Fund
158-11 Jewel Avenue
Flushing, New York 11365
A, B 1, C

Endicott-Johnson Corp.*
Endicott, New York 13760
B 1 2 3 4, D, E

Hotel Industry of N.Y. City*
Union Family Medical Fund
707 Eighth Avenue
New York, New York 10036
B 1 2 3 4 5, E

Illumination Products Industry Local 3*#
Employees Retirement Fund
158-11 Jewel Avenue
Flushing, New York 11365
A, B 1, C, E

NEW YORK—Continued

Ladies' Garment Workers Union (ILGWU)*
Union Health Center
275 Seventh Avenue
New York, New York 10001
B 3 4, D, E

Ladies' Garment Workers (ILGWU)* [2]
Eastern Region
1710 Broadway
New York, New York 10012
A, B 1 3 4, D, E

Ladies' Garment Workers (ILGWU)* [3]
Health and Welfare Fund
Northeast Department
1710 Broadway
New York, New York 10012
A, B 1 3 4, E

Laundry Workers; Amalgamated Health Center, Inc.*
Insurance Fund
222-230 East Thirty-Fourth Street
New York, New York 10016
B 3 4

Maritime Union; National*
Welfare Fund
36 Seventh Avenue
New York, New York 10011
A, B 1 2 3, E

New York Shipping Association*#
International Longshoremen's Association
Welfare and Medical and Clinical Services Fund
80 Broad Street
New York, New York 10004
A, B 3 4, C, D, E

New York Shipping Association*#
Port Watchmen's Union (Ind.)
Welfare Fund
80 Broad Street
New York, New York 10004
A, B 1 2 3 4, C, D, E

Operating Engineers, Local 295*#
Welfare Fund
1469 Flatbush Avenue
Brooklyn, New York 11210
B 1 3 4, C, E

Portable Lamp and Shade Industry*#
Pension, Hospitalization and Benefit Plan
158-11 Jewel Avenue, Room 310
Flushing, New York 11365
A, B 1 3, C, E

Shoeworkers; United, Local 563*#
Welfare Fund
23 Flatbush Avenue
Brooklyn, New York 11217
A, B 1 2 4 5, C, E

Teamsters, Local 27#
Welfare Trust Fund
27 Union Square West
New York, New York 10003
B 1 2 4, C, E

Teamsters, Local 875
Louis Hirsch Memorial Welfare Fund*
7401 Queens Boulevard
Elmhurst, New York 11373
A, B 1 2 3 4 5, C, E

Toy and Novelty Workers Local 223*#
Sick and Benefit Fund
132 West 43rd Street
New York, New York 10036
B 3 4, C, D, E

OHIO

Aerovent Fan Company, Inc.*
1 Aerovent Drive
Piqua, Ohio 45356
A, B 1 2 3 4 5

OREGON

Spokane, Portland and Seattle Railway*
Employees' Medical Association
1101 N. W. Hoyt Street
Portland, Oregon 97207
A, B 1 2 3 4 5, D, E

PENNSYLVANIA

A.F. of L. Medical Services Plan*
1226 Vine Street
Philadelphia, Pennsylvania
B 3 4, E

Sidney Hillman Medical Center*
Male Apparel Industry of Philadelphia
2116 Chestnut Street
Philadelphia, Pennsylvania 19103
B 3 4, E

Ladies' Garment Workers (ILGWU)*
Philadelphia Dress Joint Board
929 North Broad Street
Philadelphia, Pennsylvania 19123
A, B 1 3 4, E

Ladies' Garment Workers (ILGWU)* [4]
Philadelphia Area Local 190
Philadelphia, Pennsylvania
A, B 1 3 4, D, E

Philadelphia AFL-CIO Hospital Assn.*
Langdon and Cheltenham Avenue
Philadelphia, Pennsylvania
B 3 4, E

Policemen & Firemen's Medical Assn.*#
900 E. Howell Street
Philadelphia, Pennsylvania 19149
A, B 1 2 3 4, C, D, E

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[2] Unit uses Union Health Center and health center in Newark, New Jersey.
[3] A number of centers in various cities are maintained.
[4] Obtains service from health center maintained by Philadelphia Dress Joint Board.

PUERTO RICO

Seafarers, Puerto Rico Division*#
Welfare Plan
1313 Fernandez Juncas Avenue
Santurce, Puerto Rico 00908
A, B 1 2 3 4, C, D, E

RHODE ISAND

Jewelry Workers, Amalgamated#
Welfare Fund
340 Lockwood Street
Providence, Rhode Island 02907
C

SOUTH DAKOTA

Homestake Mining Company*
214 W. Main Street
Lead, South Dakota 57754
A, B 1 2 4 5, E

TEXAS

El Paso Electric Company*
Employees Society
P.O. Box 984
El Paso, Texas 79999
B 2 3 4 5, D, E

Galveston Wharves Hospital Fund*
P.O. Box 328
Galveston, Texas 77008
A, B 1 2 3 4 5, D, E

Missouri-Kansas-Texas Railroad-
Employees Hospital Assn.*
P.O. Box 340
Denison, Texas 75020
A, B 1 2 3 4 5

Santa Fe Employees Hospital Assn.*
600 South 25th Street
Temple, Texas 76501
A, B 1 2 3 4 5, E

Uvalde Rock Asphalt Co.*
Mine Employees Doctor Fund
P.O. Box 531
San Antonio, Texas 78206
B 4 5

UTAH

International Smelting and Refining
Co.*
Welfare Plan-Medical and Hospital
Services
R.F.D. No. 1
Tooele, Utah 84074
A, B 1 2 3 4 5, D, E

Union Pacific Railroad Employees
Hospital Association*
19 West South Temple Street
Salt Lake City, Utah 84101
A, B 1 2 3 4 5, D, E

Utah Parks Company Welfare
Dept.*
Cedar City
Utah 84720
A, B 1 2 3 4 5, D

VIRGINIA

Chesapeake and Ohio Railway*
Employees' Hospital Association
First and Merchants National Bank
Bldg.
Richmond, Virginia 23219
A, B 1 2 3 4

WASHINGTON

Milwaukee Hospital Association*#
1656 Medical and Dental Building
Seattle, Washington 98101
A, B 1 2 3 4 5, C, E

WISCONSIN

Milwaukee Area Truck Drivers*#
Health and Welfare Cooperative,
Inc.
6200 W. Bluemound Road
Milwaukee, Wisonsin 53213
A, B 1 2 3 4, C, E

Wisconsin Electric Power Co. Sys-
tem*
Employees' Mutual Benefit Associa-
tion
231 W. Michigan Street
Milwaukee, Wisconsin 53201
A, B 1 2 3 4 5, D

EMPLOYER-EMPLOYEE-UNION INDIVIDUAL PRACTICE PLANS

ALABAMA

A.F. of L. - A.G.C.
Associated General Contractors
Building Trades Welfare Fund
801 Saint Francis Street
Mobile, Alabama 36601
A, B 1 2 3 4

Liberty National Life Insurance
Company
(For own employees)
Security Plan
301 South 20th Street
Birmingham, Alabama 35205
A, B 1 2 3 4 5

ARIZONA

Paul Lime Plant, Inc.
Employees Insurance Fund
P.O. Drawer T
Douglas, Arizona 85607
D

ARKANSAS

Arkansas Best Corporation
301 South 11th
Fort Smith, Arkansas 72901
A, B 1 2

ARKANSAS—Continued

Weldon, Williams, and Lick
Group Hospitalization Plan
711 North A Street
Fort Smith, Arkansas 72901
A, B 1 2

CALIFORNIA

Bay Area Painters Welfare Fund
3068 - 16th Street
San Francisco, California 94103
A, B 1 2 3 4 5, D

California Portland Cement Company
Colton Cement Hospital Association
P. O. Box 111
Colton, California 92324
A, B 1 2 3 4 5, D

Coast Sugar Employees Hospital Assn.
P. O. Box 60
Tracy, California 95376
A, B 1 2 3 4 5, E

Columbia Employee's Health Plan, Inc.
921 Van Ness Avenue
Torrance, California 90501
B 1 2 3 4 5, E

Food Employers Council, Inc.#
Food Employers Dental Plan
3200 Wilshire Blvd.
Los Angeles, California 90005
C

Ladies' Garment Workers (ILGWU)
San Francisco Bay Area
San Francisco, Calfironia
B 1, E

Legallet Tanning Company
Legallet Wool Company, Inc.
Employees' Benefit Plan
San Francisco, California 94124
B 4 5

Los Angeles Firemen's Relief Assn.
Medical Plan
644 South Figueroa Street
Los Angeles, California 90017
A, B 1 2 3 4 5

MCA Inc. Health Plan
100 Universal City Plaza
Universal City, California 91608
A, B 1 2 3 4 5, C, D, E

Retail Clerks Union and Food Employers Benefit Fund
4634 West Imperial Highway
Inglewood, California 90304
A, B 1 2 3 4 5, C, D, E

Sailors' Union of the Pacific Officials'
Hospital and Medical Plan
450 Harrison Street
San Francisco, California 94105
B 1 3 4 5, C

Sheet Metal Workers Welfare Plan of Northern California
55 Hegenberger Place
Oakland, California 94621
A, B 1 2 3 4 5, E

Western Pacific Employees Medical Department
526 Mission Street
San Francisco, California 94105
A, B 2 3 4 5, E

COLORADO

Burlington Rock Island Employees Hospital Association
239 Union Station
P.O. Box 5144
Denver, Colorado 80217
A, B 1 2 3 4 5, E

The Colorado and Southern Railway Employees Hospital Association
239 Union Station
P.O. Box 5144
Denver, Colorado 80217
A, B 1 2 3 4 5, D, E

Rio Grande Employees Hospital Assn.
Room 316 Denham Building
18th and California Streets
Denver, Colorado 80202
A, B 1 2 3 4 5, D, E

CONNECTICUT

Brunswick-Carvill Benefit Plan
P. O. Box 548
Moosup, Connecticut 06503
A, B 1 3 4

Retail, Wholesale and Dept. Store Union, Local 282
Health Fund
865 Chapel Street
New Haven, Connecticut 06510
A, B 1 2

Teamsters, Local 559 Union
Health and Welfare Fund
703 Main Street
Hartford, Connecticut 06103
C, D, E

DISTRICT OF COLUMBIA

American Bakery and Confectionery Workers Union and Industrial National Welfare Fund
1120 Connecticut Avenue, N.W.
Washington, D.C. 20036
A, B 1 2 3 4 5, C, D, E

Asbestos Workers, Locals 24, 83, 88 and 100
Welfare Fund
1003 K Street, N.W.
Washington, D.C. 20001
A, B 1 2 3 4 5

Bakers Insurance Trust Fund
Benefit Plan
635 F Street, N.W.
Washington, D.C. 20004
A, B 1 3

DISTRICT OF COLUMBIA—Continued

Electrical Workers (IBEW), Local 26
Trust Fund
1003 K Street, N.W.
Washington, D.C. 20001
A, B 1 2 3 4 5

National Association of Letter Carriers
Health Benefits Plan
100 Indiana Avenue, N.W.
Washington, D.C. 20001
A, B 1 2 3 4 5, D

Rodman, Local 201 Welfare Fund
1003 K Street, N.W.
Washington, D.C. 20001
A, B 1 2 3 4 5, C

United Mine Workers of America
Welfare and Retirement Fund
907 - 15th Street, N.W.
Washington, D.C. 20005
A, B 1 2 3, D

FLORIDA

Tampa Electric Employees
Benefit Association, Inc.
P. O. Box 111
Tampa, Florida 33601
A, B 1 2 3 4 5

GEORGIA

Albany Hardware Company
Employee Benefit Association
P. O. Box 627
Albany, Georgia 31702
B 1 2

HAWAII

Hutchinson Sugar Company, Ltd.
Naalehu,
Hawaii 96772
A, B 1 2 3 4 5, D

IDAHO

Dairymen's Creamery Assn., Inc.
Box 578
Caldwell, Idaho 83605
A, B 1 2 3

Home Dairies Group Insurance Plan
618 Allumbaugh Road
Boise, Idaho 83704
A, B 1 2 3

McVey's Hospitalization Fund
P. O. Box V
161 Third Avenue West
Twin Falls, Idaho 83301
A, B 1 2 3

Sunshine Mining Company
P. O. Box 1080
Kellogg, Idaho 83837
A, B 1 2 3 4 5, D

ILLINOIS

Associated Beer Distr. of Ill.
Insurance Fund
P. O. Box 396
Springfield, Illinois 62705
A, B 1 2

Oscar F. Carlson Company
2600 Irving Pk. Road
Chicago, Illinois 60618
A, B 1

Chicago Truck Drivers, Chauffeurs and Helpers Union (2)
Health and Welfare Fund
809 West Madison Street
Chicago, Illinois 60607
A, B 1 2 3 4 5, E

DeKalb Agricultural Assn., Inc.
Employees' Mutual Welfare Assn.
Sycamore Road
DeKalb, Illinois 60115
A, B 1 2 3

Keystone Printing Service, Inc.
Hospital Benefit Plan
100 W. Madison Street
Waukegan, Illinois 60085
A

Ladies' Garment Workers (ILGWU)
Chicago and Midwest Coat and Suit
15 South Wacker Drive
Chicago, Illinois 60606
A, B 1, E

Ladies' Garment Workers (ILGWU)
Midwest Area
15 South Wacker Drive
Chicago, Illinois 60606
A, B 1, E

Ladies' Garment Workers (ILGWU)
Chicago and Midwest
Out of town Cloak
15 South Wacker Drive
Chicago, Illinois 60606
A, B 1

Pfister Hybrid Corn Company
Employee Benefit Plan
El Paso, Illinois 61738
A, B 1 2 3

A. E. Staley Manufacturing Co.
Employees Benefit Association
22nd and Eldorado Streets
Decatur, Illinois 62521
A, B 1 2 4 5, D

Teamsters Local 705
Health and Welfare Fund
220 South Ashland Boulevard
Chicago, Illinois 60607
A, B 1 2 3 4 5

INDIANA

American Bridge Company @
Employees Relief Association
Foot of Bridge Street
Gary, Indiana
A, B 1 2

Hillenbrand Industries and
Ronweber Industries
Employees' Aid Association
Batesville, Indiana 47006
A

INDIANA—Continued

Hulman and Company
Health and Welfare Plan
900 Wabash Avenue
Terre Haute, Indiana 47808
A, B 1 2 3

Pipe Trades Industry Health and Welfare Plan
620 North 13th Street
Terre Haute, Indiana 47807
A, B 1 2 3

IOWA

Central Life Assurance Company
Hospital and Surgical Benefit Plan for Home Office Employees
611 - Fifth Avenue
Des Moines, Iowa 50317
A, B 1 2 3 4 5

Dubuque Packing Company
16th and Sycamore Streets
Dubuque, Iowa 52001
A, B 1 2 3 4

Equitable Life Insurance Co. of Iowa
(For own employees)
604 Locust Street
Des Moines, Iowa 50309
A, B 1 2 3 4 5, D

National Bank Mutual Benefit Assn.
110 E. Park Avenue
Waterloo, Iowa 50703
A, B 1 2

Waterloo Daily Courier
Employees Mutual Benefit Assn.
Waterloo, Iowa 50704
A, B 1 2

KANSAS

Atchison, Topeka and Santa Fe
Employees Benefit Association
417 East Sixth Street
Topeka, Kansas 66607
A, B 1 2 3 4 5, E

KENTUCKY

Browning Manufacturing Co.
Employee Health Accident and Wage Continuation Plan
1248 E. 2nd Street
P. O. Box 687
Maysville, Kentucky 41056
A, B 1 2 3 4 5, D

LOUISIANA

Cooperative Street Railway Employees Association of N.O.
Medical Plan
302 Magazine Street, Room 201
New Orleans, Louisiana 70130
B 4

Public Service Colored Employees' Benevolent Assn. of N.O.
6544 Pauline Drive
New Orleans, Louisiana 70126
B 4 5

Rountree Olds-Cadillac Co.
Group Insurance Plan
3215 Southern Avenue
Shreveport, Louisiana 71104
A, B 1 2

West and Company
Group Medical Benefits Plan
Box G
Minden, Louisiana 71055
A, B 1 2

MAINE

G. H. Baas and Company
Shoemakers Benefit Assn.
Wilton, Maine 04292
B 4 5, D

MARYLAND

Fabricators Steel Corp.
Dental Plan
P. O. Box 288
Bladensburg, Maryland 20710
C

Postal Clerks, United Federation of
1310 Apple Avenue
Silver Spring, Maryland 20910
A, B 1 2 3 4 5, D

Postal Union, National
Health Benefit Plan
3210 Rhode Island Avenue
Mt. Rainier, Maryland 20822
A, B 1 2 3 4 5, D

MASSACHUSETTS

Adams Super Markets, Inc.
Employees Medical Benefit Plan
2 Parks Street
Adams, Massachusetts 01220
A, B 1 3

Amalgamated Cleaning and Dyeing Insurance Fund
150 Lincoln Street
Boston, Massachusetts 02111
A, B 1 2

S. Bent and Bros., Inc.
Benefit Plan
60 Mill Street
Gardner, Massachusetts 01440
A, B 1 2

Electrical Workers (IBEW)
Health and Welfare Fund
Room 315 - 10 High Street
Boston, Massachusetts 02110
A, B 1 2 3 4 5, D

Gloucester Carpenters
Health and Welfare Fund Local 910
c/o Old Colony Trust Company
One Federal Street
Boston, Massachusetts 02106
A, B 1 2 3

Grass Instrument Company
Benefit Plan
101 Old Colony Avenue
Quincy, Massachusetts 02169
A, B 1 2 3

MASSACHUSETTS—Continued

Hatters, Cap and Millinery Workers, Local 4
Health Benefit Plan
619 Washington Street
Boston, Massachusetts 02111
A, B 1, E

Johnson's Bookstore Benefit Bonus, Inc.
1379 Main Street
Springfield, Massachusetts 01101
A, B 1 2 3 4 5, C, D, E

Millinery Workers Union
Massachusetts Joint Board
554 Main Street
Worcester, Massachusetts 01608
A, B 1 2 C, E

Seafarers-New Bedford Fishermen's Welfare Fund
56 No. Water Street
New Bedford, Massachusetts 02748
A, B 1

Teamsters, Local 404
Health and Welfare Fund
549 Chestnut Street
Springfield, Massachusetts 01107
C, D, E

MICHIGAN

Michigan Carpenters' Council
Health and Welfare Fund
1850 W. Mt. Hope Avenue
Lansing, Michigan 48910
A, B 1 2 3

U. S. Rubber Tire Company
Wage Employee's Benefit Society
6600 East Jefferson Avenue
Detroit, Michigan 48232
A, B 1 3

MINNESOTA

The American Lutheran Church
Pension Plan
422 S. Fifth Street
Minneapolis, Minnesota 55415
A, B 1 2 3, D

Electrical Workers Locals 31 and 294 (IBEW) (2)
Health and Welfare Fund
203 Labor Temple
Duluth, Minnesota 55802
A, B 1 2

Farmers Union Grain Terminal Assn.
G.T.A. Hospitalization Association
1667 N. Snelling
St. Paul, Minnesota 55101
A, B 1 2 3

Green Giant Company
Benefit Association
1100 North Fourth Street
LeSueur, Minnesota 56058
A, B 1 2

Hotel and Restaurant Employees and Bartenders Welfare Fund
316 Providence Building
Duluth, Minnesota 55802
B 1 2 3 4 5

Lutheran Church in America
Ministerial Health Benefits Plan
Board of Pensions
608 Second Avenue, South
Minneapolis, Minnesota 55402
A, B 1 2 3 4 5

The Merchants National Bank of Winona
Employees Benefit Association
P.O. Box 248
Winona, Minnesota 55987
A, B 1 2 3 4, D

MISSOURI

Central Missouri Trust Co.
Basic Hospitalization Plan
238 Madison Street
Jefferson City, Missouri 65101
A, B 1 2 3

Electrical Workers, Local 124 (IBEW)
Health and Welfare Fund
2 West 40th Street
Room 310
Kansas City, Missouri 64111
C

Federal Employees Hospital Assn.
2838 Warwick Trafficway
Kansas City, Missouri 64141
A, B 1 2 3 4 5, D

Hatters, Cap and Millinery Workers, Local 55/56
Health Benefit Fund
1000 Washington Avenue
St. Louis, Missouri 63101
A, B 1

Hirsch Broadcasting Company
Health and Hospitalization Fund
324 Broadway
Cape Girardeau, Missouri 63701
A, B 1

International Longshoremen's Assn.
Local 1820 Trust
1509 Washington Avenue
St. Louis, Missouri 63122
C, E

KAW Transport Company Club
P. O. Box 8525
Sugar Creek, Missouri 64054
A, B 1 2 3

Operating Engineers, Local 513 (IUOE)
2433 South Hanley
St. Louis, Missouri 63144
A, B 1 2

Plumbers and Pipefitters
Welfare and Educational Fund
696 Grand Avenue
Hannibal, Missouri 63401
A, B 1 2 3

MISSOURI—Continued

Sheet Metal Workers, Local 36
Welfare and Pension Fund
301 South Ewing
St. Louis, Missouri 63103
A, B 1 2 3 4 5

Union Electric Company
1901 Gratiot Street
St. Louis, Missouri 63101
B 4 5, C

NEBRASKA

Outboard Marine Corporation
Cushman Motors Division
Employees Mutual Benefit Association
900 No. 21
Lincoln, Nebraska 68501
A, B 1 3

Gooch Food Products Company
510 South Street
Lincoln, Nebraska 68501
A, B 1 3

NEVADA

Carpenters, Local 1780
Health and Welfare Trust for So. Nevada
3241 North Nellis Boulevard
Las Vegas, Nevada 89110
A, B 1 2 3 4, C, E

Construction Teamsters Security Fund
P.O. Box 1988
301 Wall Street
Las Vegas, Nevada 89101
A, B 1 2 3 4 5

Electrical Workers (IBEW)
Health and Welfare Fund
3241 North Nellis Boulevard
Las Vegas, Nevada 89110
A, B 1 2 3 4, C, D

Painters, Decorators and Paperhangers, Local 159
Health and Welfare Fund
Suite 215
1111 Las Vegas Boulevard,
Las Vegas, Nevada 89104
A, B 1 2 3 5, C

NEW JERSEY

American Smelting and Refining Co.
Employee's Benefit Fund
P.O. Box 151
Perth Amboy, New Jersey 08861
A, B 1 2 3 4 5, D

Bricklayers, Masons and Plasterers, Local 47
Welfare Fund
332 Springfield Avenue
Summit, New Jersey 07901
A, B 1 2 3 4 5, C, D, E

Bricklayers, Masons and Plasterers, Local 46
Welfare Fund
332 Springfield Avenue
Summit, New Jersey 07901
A, B 1 2 3 4 5, C, E

Distillery, Rectifying, Wine and Allied Workers
Social Security Fund
66 Grand Avenue
Englewood, New Jersey 07631
A, B 1 2 3 4 5

Distillery, Rectifying Wine and Allied Workers
Wine and Liquor Salesmen of New Jersey
Local 19 Welfare Fund
24 Commerce Street
Newark, New Jersey 07102
A, B 1 2 3 4 5

Electrical Workers (IUE)
Welfare Plan
375 Murray Hill Parkway
East Rutherford, New Jersey 07073
A, B 1 2 3 4 5, C, D

Hod Carriers; Heavy and General Laborers' Locals 472 and 172
Welfare Fund of New Jersey
700 Raymond Boulevard
Newark, New Jersey 07105
C

Hod Carriers; Local 222
Welfare and Pensions Plans
1108 Broadway
Camden, New Jersey 08103
A, B 1 2 3 4 5, E

Leather Goods, Plastic, Luggage Workers, Local 62
1065 Springfield Avenue
Irvington, New Jersey 07111
E

Operating Engineers; Local 825
Welfare Fund
1100 McCarter Highway
Newark, New Jersey 07102
C, E

Painters, Decorators and Paperhangers, Local 377
Welfare Fund
130 Central Avenue
Jersey City, New Jersey 07306
E

Raritan Copper Works Benefit Assn.
P.O. Box 191
Perth Amboy, New Jersey 08862
A, B 1 2 3 4 5, D, E

U. S. Metals Refining Company
400 Middlesex Avenue
Carteret, New Jersey 07008
B 3 4 5, D

Wardell's Dairy, Inc.
Welfare Trust Fund
703 Old Corlies Avenue
Neptune, New Jersey 07753
A, B 1 2 3

NEW MEXICO

Albuqerque National Bank
Hospital and Surgical Plan for Employees
Albuquerque, New Mexico 87103
A, B 1 2 3

NEW YORK

The American News Company
131 Varick Street
New York, New York 10013
A, B 1 2 3

Box and Display Workers, Local 381
Group Insurance Fund
170 Old Country Road
Mineola, New York 11501
B 1 2 3 4 5

Bricklayers Insurance and Welfare Fund
178 East 85th Street
New York, New York 10028
A, B 1 2 3, C, D

Bricklayers, Locals 19 and 88
Welfare Fund
P. O. Box 208
Utica, New York 13503
C, E

Buffalo Laborers Benefit Funds
481 Franklin Street
Buffalo, New York 14202
A, B 1 2 3 4 5, C, D, E

Building Service Employees Union
Local 32B Welfare Fund
23 East 26th Street
New York, New York 10010
B 3 4, E

Building Service Employees, Local 54
Theatre, Amusement and Cultural Workers
Welfare Fund
1650 Broadway
New York, New York 10019
A, B 1 2 3 4 5, E

Carpenters; Buffalo Council
Health Care Fund
300 Kensington Avenue
Buffalo, New York 14214
A, B 1 2 3 4 5, D, E

Carpenters; Nassau County
Welfare Fund
1 Commercial Avenue
Garden City, New York 11530
A, B 1 2 3 4 5, C, D, E

Carpenters; N.Y. City District Council
Welfare Fund
204-8 East 23rd Street
New York, New York 10010
A, B 1 2 3 4 5, E

Clothing Workers of America; Amalgamated Local 324
Disability, Relief and Benefit Fund
160 Fifth Avenue
New York, New York 10010
A, B 1, E

Clothing Express Workers, Local 240
Welfare Fund
160 Fifth Avenue
New York, New York 10010
E

Composition Roofers Damp and Waterproof Workers Assn. Local 8
Insurance and Trust Fund
467 Dean Street
Brooklyn, New York 11217
A, B 1 2 3, E

Consolidated Edison Employees Mutual Aid Society
4 Irving Place
New York, New York 10003
A, B 1 2 3 4 5, C, D, E

Drug and Hospital Union, AFL CIO
Local 1199 Benefit Plan
709 Eighth Avenue
New York, New York 10036
A, B 1 2 3 4 5, C, E

Electrical Workers, Local 1783 (IBEW)
Welfare Fund
470 Mamaroneck Avenue
White Plains, New York 10605
E

Electrical Workers, Local 408 (IUE)
United Optical Workers Insurance Fund
150 Fifth Avenue
New York, New York 10011
B 1 2 3 4 5

Electrical Workers, Local 1249 (IBEW)
Insurance Fund
602 Chamber of Commerce Building
Syracuse, New York 13202
A, B 1 2 3 4 5, C, D, E

ERM Health and Group Insurance Fund
100 Clinton Street
Brooklyn, New York 11201
B 2 3 4

Harold Faggen Associates Welfare Fund
853 Broadway
New York, New York 10003
A, B 1 2 3 4 5, C, D, E

Fritzsche Brothers Doctor Visits Plan
76 Ninth Avenue
New York, New York 10011
B 2 4 5

Furniture Workers Insurance Fund
700 Broadway
New York, New York 10003
A, B 1 2 3 4 5, C, D

General Electric
Medical Electric
Medical Care Plan for Pensioners
570 Lexington Avenue
New York, New York 10022
A

NEW YORK—Continued
Hatters, Cap and Millinery Workers Local 92
Millinery Designers, Foremen and Foreladies
Health Fund
49 W. 37th Street
New York, New York 10018
A, B 1 2 3
Hatters, Cap and Millinery Workers Local 93
Health and Welfare Fund
Beacon, New York 12508
A, B 1 2 3, E
Hatters, Cap and Millinery Workers
Health Fund
49 W. 37st Street
New York, New York 10018
A, B 1 2 3
Hatters, Cap and Millinery Workers
National Health and Welfare Fund
245 Fifth Avenue
New York, New York 10016
A, B 1 2, E
Hatters, Cap and Millinery Workers, Local 98
Millinery Salesmen's Union
Health Fund
49 W. 37st Street
New York, New Pork 10018
A, B 1 2 3
Sidney Hillman Health Center of Rochester
750 East Avenue
Rochester, New York 14607
B 3 4, E
Laborers Union, Local 66
Welfare Fund
1600 Walt Whitman Road
Melville, New York 11746
A
Laborers Union, Local 147
Construction Workers Welfare Fund
c/o Harold Faggen Associates, Inc.
853 Broadway
New York, New York 10003
A, B 1 2 3 4 5, E
Laborers Union, Local 1298
Nassau and Suffolk Counties
Welfare Fund
681 Fulton Avenue
Hempstead, New York 11553
A, B 1, D, E
Hotel and Restaurant Employees, Local 1 Dining Room Employees
Welfare Fund
Room 413 Wilson Building
Syracuse, New York 13202
A, B 1 2
Hotel and Restaurant Employees, Local 164
Insurance Fund
533 Greenwich Street
Hempstead, New York 11550
A, B 1 2 3 4 5, E
IBM Employees Health Association
1701 North Street
Endicott, New York 13760
A, B 1
Jewelry Manufacturers Association Local 1
Welfare Fund
133 West 44th Street
New York, New York 10036
A, B 1 2 3 4 5, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 99
275 Seventh Avenue
New York, New York 10001
A, B 1 4, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 124
117 West 46th Street
New York, New York 10036
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 177
117 West 46th Street
New York, New York 10036
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 105
575 Eighth Avenue
New York, New York 10018
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 102
22 W. 38th Street
New York, New York 10018
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 20
273 West 39th Street
New York, New York 10018
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 98
29-31 East 22nd Street
New York, New York 10010
A, B 1, 4, E
Ladies' Garment Workers (ILGWU)[5]
New York City Local 91
100 East 17th Street
New York, New York 10018
A, B 1, E
Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 82
22 West 38th Street
New York, New York 10018
B 1, E

[5] Contracts with ILGWU's Health Center at 275 Seventh Ave., N.Y., N.Y., for physicians' service at the Center; self-insures for other benefits such as hospitalization, surgery.

NEW YORK—Continued

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 117
22 West 38th Street
New York, New York 10018
B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 9
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 10
22 West 38th Street
New York, New York 10018
B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 23/25
22 West 38th Street
New York, New York 10018
B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 35
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 48
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Cloak Local 64
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
Out-of-town Cloak
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
Cloak South Jersey - Philadelphia
22 West 38th Street
New York, New York 10018
B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York Dress Local 10
218 West 40th Street
New York, New York 10018
B 4, E

Ladies' Garment Workers (ILGWU)[5]
New York Dress Local 22
218 West 40th Street
New York, New York 10018
B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York Dress Local 60
218 West 40th Street
New York, New York 10018
B 4, E

Ladies' Garment Workers (ILGWU)[5]
New York Dress Local 89
218 West 40th Street
New York, New York 10018
B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 66
218 West 40th Street
New York, New York 10018
A, B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 62
101 West 31st Street
New York, New York 10001
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 60A
218 West 40th Street
New York, New York 10018
A, B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 40
44 West 37th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 38
117 West 46th Street
New York, New York 10036
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 35
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 155
815 Broadway
Brooklyn, New York 11206
A, B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 32
275 Seventh Avenue
New York, New York 10001
A, B 1, E

[5] See footnote page 95.

NEW YORK—Continued

Ladies' Garment Workers (ILGWU)[5]
New York City Local 23/25
275 Seventh Avenue
New York, New York 10001
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 10
218 West 40th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 132
1710 Broadway
New York, New York 10017
A, B 1 4, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 30
275 Seventh Avenue
New York, New York 10001

Ladies' Garment Workers (ILGWU)
Kentucky Area
570 Seventh Avenue
New York City Local 64
22 West 38th Street
New York, New York 10018
A, B 1, E

Ladies' Garment Workers (ILGWU)[5]
New York City Local 64
22 West 38th Street
New York, New York 10018
A, B 1, E

Leather Goods, Plastic and Novelty Workers
Health and Welfare Fund of the Four Joint Boards
265 West 14th Street
New York, New York 10011
A, B 1 2 3, E

John A. Manning Paper Co., Inc.
Welfare Association
P.O. Box 328
Troy, New York 12181
A, B 1 3 4 5, C

Mason Tenders District Council (NY)
215 Park Avenue South
New York, New York 10002
A, B 1 2 3 4 5, C, D

Meatcutters and Butcher Workers of North America, Amalgamated
Trustees of Local 500
Welfare Fund
470 Mamaroneck Avenue
White Plains, New York 10605
E

Meatcutters, Local 662
Salesmen and Poultry Workers Union of Greater N. Y.
Welfare Fund
799 Broadway
New York, New York 10003
B 4, E

Meatcutters, Local 627
Provision Salesmen and Distrs. Union
Welfare Trust Fund
27 Union Square
New York, New York 10003
A, B 1 2 3 4 5, E

Meatcutters, Local 491
Shochtim Health and Welfare Fund
799 Broadway
New York, New York 10003
A, B 1 3

Meat Trade Institute, Inc.
Trust Fund
420 Lexington Avenue
New York, New York 10017
B 3, E

Mosaic and Terrazzo
Welfare Fund
23 East 26th Street
New York, New York 10010
A, B 1 2 3 4 5, C, E

Norton Coated Abrasive and Tape Div.
Employee Welfare Association
Troy, New York 12181
B 3, E

Operating Engineers, Local 25
Marine Division
Welfare Pension and Vacation Plans
17 Battery Place Room 2245
New York, New York 10004
A, B 1 2 3 4 5, E

Operating Engineers, Locals 17, 106, 410, 463, 545 and 832
Joint Welfare Fund
4325 S. Salina Street
Syracuse, New York 13205
A, B 1 2 3 4 5, D, E

Painters' Insurance Fund of Westchester
600 North Broadway
White Plains, New York 10603
A, B 1 2 3 4 5

Painters District Council No. 4
Health Trust Fund
376 Virginia Street
Buffalo, New York 14201
E

Perishable Food Industry Welfare Fund
c/o Harold Faggen Associates, Inc.
853 Broadway
New York, New York 10003
B 1 2 3 4 5, C, E

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[5] See footnote page 95.

NEW YORK—Continued

Plastering Industry, Local 30
Welfare Fund
One Nevins Street, Room 708
Brooklyn, New York 11218
E

Plumbers, Local 129
Welfare Fund
2902 Lockport Road
Niagara Falls, New York 14304
A, B 1 2 3

Plumbers, Local 79
Welfare Fund
666 Bleecker Street
Utica, New York 13501
A, B 1 2 3

Production Workers, Local 148
Welfare Fund
147-14 Archer Avenue
Jamaica, New York 11435
C, E

Pulp, Sulphite and Paper Mill Workers, Local 107
Labor Management Trust Fund
434 Albee Square
Brooklyn, New York 11201
A, B 1 2 4 5, D, E

Port of Albany Employers—International Longshoremen Assn.
Welfare Fund
Port of Albany
Albany, New York 12202
A, B 1 2 3 4 5, C

Pulp, Sulphite and Paper Mill Workers, Local 413
Welfare Trust Fund
1 Union Square
New York, New York 10003
B 1 2 3 4 5, E

Retail, Wholesale and Chain Store Food Employees Union, Local 338
Health and Welfare Fund
130 West 42nd Street
New York, New York 10036
A, B 1 2 3 4 5, E

Retail, Wholesale and Department Store Union District 65
15 Astor Place
New York, New York 10002
A, B 1 2 3 4 5, E

Scott Associates
Scott Paper Company
Front and Market Streets
Fort Edward, New York 12828
B 3, C, E

Shepard Niles Crane and Hoist Corp.
Montour Falls, New York 14865
A B 1 2 3 4 5

Sheet Metal Workers, Local 137
Insurance Fund
7 East 15th Street
New York, New York 10003
A, B 1 2 3 4 5, D, E

Staff Officers Assn. of America
Pension Welfare Plan
114 Liberty Street
New York, New York 10006
A, B 1 2 3, D, E

Teamsters, Local 239
Synthetic and Specialty Products Welfare Fund
252-17 Northern Boulevard
Little Neck, New York 11363
E

Teamsters, Local 202
Welfare Fund
N.Y. City Terminal Market, RM. 12A
Hunts Point and East Bay Avenues
Bronx, New York 10474
A, B 1 2 3 4 5, C, E

Teamsters, Local 138
Welfare Fund No. 1
23-03 45 Road
Long Island City, New York 11101
E

Teamsters, Local 138
Welfare Fund No. 2
23-03 45 Road
Long Island City, New York 11101
E

Teamsters, Local 210
Health and Insurance Fund
345 West 44th Street
New York, New York 10036
E

Teamsters, Local 239
Welfare Fund
252-17 Northern Boulevard
Little Neck, New York 11363
E

Tile Layers Union, Local 52
Insurance and Welfare Fund
350 Broadway
New York, New York 10013
A, B 1 3, D, E

Tile Layers Helpers, Local 88
Welfare Plan
c/o Harold Faggen Associates, Inc.
853 Broadway
New York, New York 10003
A, B 1 2 3 4 5, C, D, E

E. H. Titchener and Company
Employees Benefit Plan
67 Clinton Street
Binghamton, New York 13902
A, B 1 2 3 4, C, E

Typographical Union, Local 915, Long Island
Welfare Trust Fund
166 Old Country Road
Hicksville, New York 11801
A, B 1 2 3 4 5, D

Union Dime Savings Bank
Union Dime Club
Surgical Plan
1065 Avenue of the Americas
New York, New York 10018
A, B 1 3

NEW YORK—Continued

Van Raalte Company, Inc.
Mutual Aid Association
417 Fifth Avenue
New York, New York 10016
A, B 1 2 3

Western Savings Bank Hospitalization Plan
438 Main Street
Buffalo, New York 14202
A, B 1 2 3 4, D

Woodworkers (IWA), Local 55 I.U.P.P.E.
Interstate Employees Welfare Fund
316 West 43rd Street
New York, New York 10019
D, E

NORTH CAROLINA

Carolina Panel Company, Inc.
Lexington,
North Carolina 27292
A, B 1 2 3

Carolina Securities Corporation
North Carolina National Bank Bldg.
Raleigh, North Carolina 27601
A, B 1 2 3 4 5, D

Hennis Freight Lines, Inc.
P.O. Box 612
Winston Salem, North Carolina 27102
A, B 1 2

Sou-Tex Chemical Company, Inc.
P.O. Box 866
Mt. Holly, North Carolina 28120
A, B 1

OHIO

Allis Chalmers Manufacturing Co.
Mutual Aid Trust
4620 Forest Avenue
Norwood, Ohio 45212
B 1 2 3 4 5, D, E

BancOhio Corporation
51 North High Street
Columbus, Ohio 43216
A, B 1 2

Bricklayers and Masons, Local 5
Health and Welfare Fund
2105 East 21st Street
Cleveland, Ohio 44115
A, B 1 2 3 4 5, C

Cuyahoga, Lake, Grauga, Ashtabula Counties 'Carpenters' District Council @
Hospitalization Plan
3621 Chester Avenue
Cleveland, Ohio 44114
A, B 1 2 3

Firestone Tire and Rubber Co.
Health and Welfare Plan
1200 Firestone Parkway
Akron, Ohio 44317
A, B 1 2 3

B. F. Goodrich Company 500 S. Main Street
Akron, Ohio 44318
A, B 2 3

Goodyear Tire and Rubber Company
1144 East Market Street
Akron, Ohio 44316
A, B 2 3

Goodyear Relief Association
1144 E. Market Street
Akron, Ohio 44316
A, B 1 2 3 4 5, E

Hercules Trouser Company
Employee Welfare Plan
570 S. Front Street
Columbus, Ohio 43216
A, B 1

The Home Missioners of America
11295 Princeton Pike
Cincinnati, Ohio 45246
A, B 1 2

Ladies' Garment Workers (ILGWU)
Cleveland Joint Board
3233 Euclid Avenue
Cleveland, Ohio 44115
A, B 1 4, E

The Marting Brothers Co.
Sixth and Chillicothe Streets
Portsmouth, Ohio 45662
A, B 1 2 3

National Cash Register Company
Retired Employees Beneficiary Assn.
Main and K Streets
Dayton, Ohio
A, B 1 2 3

National Machinery Company
Mutual Benefit Association
P.O. Box 747
Tiffin, Ohio 44883
A, B 1 2 3

Ohio Injector Company
Employees' Benefit Association
Main Street
Wadsworth, Ohio 44281
A

Pipe Machinery Company
Hospital and Surgical Plan
29100 Lakeland Boulevard
Wickliffe, Ohio 44092
A, B 1 2

Sauder Woodworking Company
502 Middle Street
Archbold, Ohio 43502
A, B 1 2 3 4 5

O. M. Scott and Sons Company
Sixth and Plum Streets
Marysville, Ohio 43040
A, B 1 3, E

Teamsters, Local 407
Insurance Fund
1625 Illuminating Building
55 Public Square
Cleveland, Ohio 44113
A, B 1 2 3 4 5, C, E

OHIO—Continued

Teamsters, Local 964
Insurance Fund
1625 Illuminating Building
Cleveland, Ohio 44113
A, B 1 2 3 4, C, E

OKLAHOMA

Sand Springs Railway
Employees Hospital Association
P. O. Box 128
Sand Springs, Oklahoma 74063
A, B 1 2 3 4 5, D

Video Independent Theaters, Inc.
Employee's Benefit Trust Fund
P. O. Box 1334
Oklahoma City, Oklahoma 73101
A, B 1 2 3 4 5

OREGON

Ladies' Garment Workers (ILGWU)
Local 70
Health and Welfare Fund
515 Dekum Building
Portland, Oregon
E

Portland General Electric Co.
Employees Beneficial Association
3700 SE 17 Avenue
Portland, Oregon 97202
A, B 3, D

PENNSYLVANIA

Ashland Knitting Mills, Inc.
Health and Welfare Fund
Front and Chestnut Streets
Ashland, Pennsylvania 17921
A, B 1

Bessemer and Lake Erie Railroad Co.
Mutual Benefit Association
P. O. Box 723
Greenville, Pennsylvania 16125
A

Bricklayers, Local 64
Welfare Fund
1036 Rising Sun Avenue
Philadelphia, Pennsylvania 19140
A, B 1 2 3 4 5

Carpenters District Council of So. Jersey
Health and Welfare Plan
Suite 321 Public Ledger Building
Philadelphia, Pennsylvania 19106
A, B 1 2 3, D

Cement Masons, Local 526
Welfare Fund
2606-10 California Avenue
Pittsburgh, Pennsylvania 15212
B 1 2 3

Colonial Products Relief Assn.
P.O. Box 231
Red Lion, Pennsylvania 17356
A, B 1 2 3

Colonial Products Company
Relief Association
108 North 8th Street
Mifflinburg, Pennsylvania 17844
A, B 1 2 3

Eastern Gas and Fuel Associates, Coal Division
Retired Employees Benefit Fund
Koppers Building
Pittsburgh, Pennsylvania 15219
A, B 1 2 4

First National Bank Employees Benefit Fund
Carbondale, Pennsylvania 18407
A, B 1 2

Garment Workers; United (UGW), Local 140
Sick and Death Fund
201 No. Broad Street
Philadelphia, Pennsylvania 19107
A, B 1

Luger Employee Club
Box 600
Beaver Falls, Pennsylvania 15010
A, B 1 2 3

Male Apparel Industry
Reuben Block Health Fund
137 N. 7th Street
Allentown, Pennsylvania 18101
B 3 4

National Bank of Chester County and Trust Co.
Hospitalization-Surgical Plan
West Chester, Pennsylvania 19380
A, B 1 3

Operating Engineers, Eastern Penna. and Delaware
Welfare Fund
248 N. 12th Street
Philadelphia, Pennsylvania 19107
A, B 1 2 3 4 5

Plumbers, Local 690, Philadelphia and Vicinity
Welfare Fund
2555 Orthodox Street
Philadelphia, Pennsylvania 19137
A, B 1 2 3 4 5, E

Reidler Knitting Mills
757 West Broad Street
Hazelton, Pennsylvania 18201
A, B 1 2

Rex Carpenter Packing Company
Eager Beaver Lumber Company
RD #1 Route 408
Townville, Pennsylvania 16360
A, B 1 2 3

Arthur F. Schultz Company
Employees Mutual Benefit Assn.
212 East 18th Street
Erie, Pennsylvania 16503
A

Scott Tissue Beneficial Assn.
Scott Paper Company
Front and Market Street
Chester, Pennsylvania 19013
B 3, C, E

PENNSYLVANIA—Continued

L. Shellenberger and Sons
Hospitalization Plan
Richfield, Pennsylvania 17086
A, B 1

Somerset Shirt and Pajama Co.
P.O. Box 472
R.D. #1
Somerset, Pennsylvania 15501
A, B 1 2

Teamsters Health and Welfare Fund of Philadelphia and Vicinity
530 Walnut Street
12th Floor
Philadelphia, Pennsylvania 19106
A, B 1 2 3, C, E

Textile Machine Works
Employee's Benefit Association
P. O. Box 64
Wyomissing, Pennsylvania 19610
A, B 1 2 34 5

United Presbyterian Pension Plan
Board of Pensions
Witherspoon Building
Philadelphia, Pennsylvania 19065
A, B 1 2 3 4 5, D

Victor F. Weaver, Inc.
Hospitalization Plan
403 S. Custer Avenue
New Holland, Pennsylvania 17557
A, B 1 2 3

PUERTO RICO

Cooperative Azucarera Los Canos
Hospitalization Plan
P.O. Box 654
Arecibo, Puerto Rico 00612
A, B 1 2 3 4, D

Fajardo Eastern Sugar Associates
Welfare Fund of Factory and RR Central Fajardo
Jorge Bind Leon #2 St.
Box 112
Fajardo, Puerto Rico 00648
A, B 1 2 3 4 5, C, D, E

Plan de Beneficencia De Central Colso
Central Colso
Coloso, Puerto Rico 00641
A, B 1 3 4 5, D, E

Puerto Rico Teachers Assn.
Health Program
Box 1088
Hato Rey, Puerto Rico 00919
A, B 1 2 3 4, E

Sindacto Obrero Insular
Plan de Binestar
1903 Cayey Street, Stop 26
Santurce, Puerto Rico 00908
A, B 1 2 3 4, C, E

TENNESSEE

Genesco Inc.
111 7th Avenue N.
Nashville, Tennessee 37206
A, B 1

TEXAS

Baytown Mutual Benefit Assn.
P.O. Box 3919
Baytown, Texas 77520
E 4

Fort Worth and Denver Railway Co.
Employees Hospital Association
307 West Sixth Street
Fort Worth, Texas 76101
A, B 1 2 3 4 5, C, E

Gulf Coast Lines
Employees Hospital Association
1601 W. Alabama
Houston, Texas 77006
A, B 1 2 3 4 5

Southern Minerals Corporation
Employees Mutual Health Assn.
Room 227 Somico Building
P.O. Box 716
Corpus Christi, Texas 78403
A, B 1 2 3 4 5, D

Texas City Terminal Railway Company Hospital Assn.
P.O. Box 591
Texas City, Texas 77590
A, B 1 2 3 4 5, E

Texas and Pacific Employees Hospital Assn.
P.O. Box 1208
Marshall, Texas 75670
A, B 1 2 3 4 5

UTAH

Beneficial Life Insurance Co.
(For own employees)
Health Insurance plan
47 West South Temple
Salt Lake City, Utah 84101
A, B 1 2 3 4 5

Granite Mill and Fixture Co.
Employee Fund
P.O. Box 875
Salt Lake City, Utah 84110
A, B 1 2

VIRGINIA

Colonial Williamsburg
Local Doctors Plan
Williamsburg, Virginia 23185
B 4 5

Dixie Jute Bagging Corp.
Employees' Benefit Association
110 Colley Avenue
Norfolk, Virginia 23510
B 1 2 3 4, C, E

Lynchburg Hosiery Mills Assn. #1
2734 Fort Avenue
Lynchburg, Virginia 24501
A, B 1 3

Lynchburg Hosiery Mills Assn. #2
2724 Fort Avenue
Lynchburg, Virginia 24502
A, B 1 3

VIRGINIA—Continued

Morganstern Pants Company
401 Willis Street
Fredericksburg, Virginia 22401
A, B 1

WASHINGTON

Snohomish County Beneficial Assn. Inc.
Labor Temple Annex
Labor Temple
Everett, Washington 98201
A, B 1 2 3 4 5

WEST VIRGINIA

Ensign Electric and Mfg. Co. Welfare Fund
914 Adams Avenue
Huntington, West Virginia 25704
A, B 1 2

WISCONSIN

Aid Association for Lutherans Retired Employees Medical Insurance Plan
222 West College Avenue
Appleton, Wisconsin 54911
A, B 1 2 3 4 5, D

Combined Locks Paper Co. Employees Benefit Association
Combined Locks, Wisconsin 54113
C, E

Consolidated Papers, Inc. Employees' Benefit Association
P.O. Box 50
Wisconsin Rapids, Wisconsin 54494
A, B 1 2 3 4 5, C, E

Cutler-Hammer Employees' Mutual Benefit Association
4201 North 27th Street
Milwaukee, Wisconsin 53216
A, B 1 2 3 4 5, D, E

Daniels Manufacturing Co. Hospital and Surgical Plan
P.O. Box 220
Rhinelander, Wisconsin 54501
A, B 1 2 3

S. C. Johnson and Sons, Inc. Johnson Mutual Benefit Assn.
1525 Howe Street
Racine, Wisconsin 53403
B 1 2 3 4 5, D

Junior House, Inc. Health and Benefit Fund
710 So. Third Street
Milwaukee, Wisconsin 53204
A, B 1 2 3

Kimberly-Clark Corporation Mutual Benefit Association
North Lake Street
Nennah, Wisconsin 54956
C, E

Menasha Utilities Employees Benefit Assn.
182 Main Street
Menasha, Wisconsin 54952
A, C, E

Milwaukee Roofers Welfare Fund
3817 W. Fond du Lac Avenue
Milwaukee, Wisconsin 53216
A, B 1 2 3

Monark Supply Co. and Car Parts, Inc. Mutual Benefit Plan
5829 W. National Avenue
West Allis, Wisconsin 53214
A, B 1 2 3

Nekoosa-Edwards Paper Company NEPCO Employees Mutual Benefit Assn.
Port Edwards, Wisconsin 54469
A, B 1 2 3 4

Ed Phillips & Sons Co., Inc., Health Fund
P. O. Box 869
Eau Claire, Wisconsin 54701
A, B 1

Plumber and Steamfitter Welfare Trust
145 Main Street
Green Bay, Wisconsin 54301
A, B 2 3 4, D

H. C. Prange Company Associates' Mutual Aid Society
727 North Eighth Street
Sheboygan, Wisconsin 53081
A, B 1 2 3 4 5

Thilmany Pulp and Paper Co. Employees Association
Kaukauna, Wisconsin 54130
C, E

PRIVATE GROUP MEDICAL CLINIC PLANS

CALIFORNIA

Associated Doctor's Health Foundation*@
1125 Cherry Street
Long Beach, California 90813
B 3 4

Frank M. Close, M.D. and Staff*
728 20th Street
San Francisco, California 94107
A, B 1 2 3 4 5

Howard F. Detwiler, M.D.*
Van Nuys Medical Clinic
Burbank Medical Clinic
San Fernando Medical Clinic
7555 Van Nuys Blvd.
Van Nuys, California 91405 and
2301 W. Magnolia Boulevard
Burbank, California 91506
B 1 2 3 4 5, E

CALIFORNIA—Continued

Palo Alto Medical Clinic*
300 Homer Avenue
Palo Alto, California 94301
B 1 2 3 4 5

Ross-Loos Medical Group*
947 West 8th Street
Los Angeles, California 90017
B 1 2 3 4 5, E

MINNESOTA

West Duluth Clinic*
4325 31 Grand Avenue
Duluth, Minnesota 55807
B 3 4

NEW YORK

Boro Medical Center*@
104 Fifth Avenue
New York, New York 10011
B 1 2 3 4 5 E

OREGON

Eugene Hospital and Clinic*
Medical Coverage Plan
1162 Willamette Street
Eugene, Oregon 97401
A, B 1 2 3 4 5

PENNSYLVANIA

Russellton Medical Group*
1260 Martin Avenue
New Kensington, Pennsylvania 15068
B 3 4 5, E

VIRGINIA

Clinch Valley Clinic Hospital*
Richlands,
Virginia 24641
A, B 1 2 3

Mattie Williams Hospital and/or
Grundy Hospital, Inc.*
200 Washington Square
Richlands, Virginia and/or
Grundy, Virginia
A, B 1 2 3

WASHINGTON

Community Medical Services, Inc.*
1106 Summit
Seattle, Washington 98101
A, B 1 2 3 4 5, D, E

Western Clinic*
521 South K
Tacoma, Washington 90405
A, B 1 2 3 4 5, D, E

PRIVATE GROUP DENTAL CLINIC PLANS

CALIFORNIA

Naismith Dental Group#
3772 Howe Street
Oakland, California 94611
C

Drs. Schoen, Sakai, Simms, Eisman, Simon and Sugiyama#
25617 Dodge Avenue
Harbor City, California 90710
C

DISTRICT OF COLUMBIA

Jack Diener D.D.S.#
4545 Connecticut Avenue
Washington, D.C. 20008
C

DENTAL SERVICE CORPORATION PLANS

CALIFORNIA

California Dental Service
101 Howard Street
San Francisco, California 94105
C

CONNECTICUT

Connecticut Dental Service, Inc.
P.O. Box 1904
New Haven, Connecticut 06509
C

HAWAII

Hawaii Dental Service
1149 Bethel Street
Honolulu, Hawaii 96813
C

ILLINOIS

Illinois Dental Service@
Suite 904
1525 East 53rd Place
Chicago, Illinois 60615
C

KENTUCKY

Kentucky Dental Service@
1940 Princeton Dr.
Louisville, Kentucky 40205
C

MAINE

Maine Dental Service Corps.@
97-A Western Avenue
Waterville, Maine 04901

MICHIGAN

Michigan Dental Association
Dental Care Inc.
P.O. Box 416
Lansing, Michigan 48902
C

NEW HAMPSHIRE

New Hampshire Dental Service Corp.
27 Clinton Street
Concord, New Hampshire 03301
C

NEW YORK

New York Dental Service Corp.
30 East 42nd Street
New York, New York 10017

OHIO

Ohio State Dental Care Corporation
40 South Third Street
Columbus, Ohio 43215
C

OREGON

Oregon Dental Service Corp.
610 Southwest Broadway
Portland, Oregon 97205
C

PENNSYLVANIA

Pennsylvania Dental Service Corp.@
217 State Street
Harrisburg, Pennsylvania 17101
C

RHODE ISLAND

Rhode Island Dental Service Corp.@
901 Union Trust Building
Providence, Rhode Island 02903
C

UTAH

Delta Dental Plan of Utah
8496 Fourth South
Salt Lake City, Utah 84102
C

VERMONT

Vermont Dental Service Admin. Corp. @
256 Pearl Street
Burlington, Vermont 05401
C

WASHINGTON

Washington Dental Service
2208 Northwest Market Street
Seattle, Washington 98107
C

WISCONSIN

Wisconsin Dental Service, Inc.
Box 508
Stevens Point, Wisconsin 54481
C

APPENDIX B

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
WASHINGTON, D.C. 20201

Office of Research
and Statistics

REFER TO RS:L

Gentlemen:

We are making a survey of all so-called "independent" health insurance plans--all organizations directly providing health services or health benefits on a prepayment or insurance basis which are not Blue Cross or Blue Shield plans or insurance companies. Such surveys have been made every three or four years for the past 20 years, with information being obtained in the intervening years from 30 or so of the larger plans. These surveys are the sole source of national data on the enrollment (persons covered) and finances of health insurance organizations other than Blue Cross-Blue Shield plans and insurance companies. Such data, along with analogous data collected and made available by the insurance industry and Blue Cross and Blue Shield, provide much needed and widely used information on the number of and proportion of the population having health insurance protection and on the public's expenditures for, and benefit expenditures under, such insurance. The enclosed material indicates the use made of data collected in our surveys.

It is our understanding that your organization directly provides or pays for health care benefits on a prepayment basis and hence comes within the terms of our survey. If this is so, would you kindly fill out and return the enclosed questionnaire? If we are misinformed or your organization no longer comes within the terms of the survey, please let us know that also.

The questionnaire is similar to that used in past years and can be completed from your records with little effort. With respect to the financial data requested, audited figures are not necessary. We would much rather have approximate, preliminary data for 1968 than wait until final audited data become available.

The data you supply will be held in confidence and used for statistical purposes only.

It would be helpful to us in having a full understanding of the nature, organization, coverage and finances of your plan if you would send along with the completed questionnaire a copy of your most recent annual report and of pamphlets describing the benefits, charges, contributions, organization, etc., of your plan.

A franked envelop and an extra franked label requiring no postage are enclosed for your use.

Your assistance in making the survey successful will be most appreciated. Would you kindly endeavor to reply within two weeks?

Sincerely yours,

Louis S. Reed

Louis S. Reed
Private Health Insurance Studies

Enclosures - 2
R and S Note No. 16--1968
Reprint "Private Health Insurance in the United States, 1967"

Form Approved
Budget Bureau No. 72-R069.
Expires 3 31 70

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
WASHINGTON, D.C. 20201

1969 SURVEY OF INDEPENDENT HEALTH INSURANCE PLANS

(All organizations other than Blue Cross – Blue Shield plans and insurance companies)

NOTE: Data you supply will be held in confidence and used for statistical purposes only.

NAME OF PLAN OR ORGANIZATION

ADDRESS

SPONSORING ORGANIZATION *(If not indicated above)*

A. Type of Plan or Sponsor *(Check one)*

- ☐ 1. Community-Consumer-Cooperative
- ☐ 2. Employer-Employee-Union
  - ☐ a. Union-Employer(s) Welfare or Pension Fund
  - ☐ b. Employer or Employer Association
  - ☐ c. Union
  - ☐ d. Employee Association
  - ☐ e. Employer-Employee Association
- ☐ 3. Private Group Medical Clinic
- ☐ 4. Private Group Dental Clinic
- ☐ 5. Dental Society *(Dental Service Corporation)*
- ☐ 6. Other *(Specify)* _____

B. Arrangements through which Medical-Dental Services are mainly provided: *(Check one)*

- ☐ 1. By fee or indemnity payments to private practitioners or reimbursement of covered persons for expenses incurred
- ☐ 2. By own medical *(dental)* clinic or health center and salaried medical and/or dental staff
- ☐ 3. By contract with one or more medical *(dental)* groups
- ☐ 4. Other *(Specify)* _____

C. Medical Care Facilities and Staff:

1. Does Plan Have Its Own:	YES	NO	2. If answer is yes to any of C-1, please give number of salaried professional personnel on staff	FULL TIME	PART TIME
a. Hospital(s)					
b. Clinic or Health Center			a. Physicians		
c. Dental Clinic			b. Dentists		
d. Pharmacy			c. Pharmacists		
e. Optical Unit			d. Optometrists		

3. If Plan Contracts with Medical or Dental Groups for Service, please give:

A. NUMBER OF GROUPS	B. NUMBER OF PHYSICIANS IN THESE GROUPS	C. NUMBER OF DENTISTS IN THESE GROUPS

D. Number of persons eligible to receive specified health care or benefits directly provided or paid for by this plan, as of December 31, 1968, *(or nearest available date). (Enter in appropriate space number of persons eligible for specified service or benefit; enter none, when specified service or benefit is not provided.) (If organization contracts with Blue Cross–Blue Shield, an insurance company or other health insurance organization for certain services or benefits DO NOT ENTER persons eligible for these contracted services or benefits on relevant line.)*

TYPE OF HEALTH CARE OR BENEFIT	ALL AGES			DISTRIBUTION OF TOTAL PERSONS BY AGE	
	SUBSCRIBERS EMPLOYEES RETIREES	DEPENDENTS	TOTAL PERSONS	UNDER AGE 65	AGED 65 AND OVER
1. Hospital care					
2. Physician service: (a) Surgical-Obstetrical					
(b) In-hospital medical visits					
(c) X-ray and lab. outside hospital					
(d) Office and clinic visits					
(e) Home visits					
3. Dental care *(cleaning, fillings, etc.)*					
4. Drugs outside hospital *(See H, Page 4)* (a) On prepayment basis					
(b) On other basis					
5. Visiting nurse service					
6. Special duty nursing (a) Hospital					
(b) Home					
7. Vision care (a) Refractions					
(b) Eyeglasses *(See H, Page 4)* (1) On prepayment basis					
(2) On other basis					
8. Nursing home care *(includes extended care facilities)*					
9. Appliances *(Artificial limbs, braces, etc.)*					
10. Other services *(Specify)*					

E. Area served:

If appreciable number of persons served reside in a State or States other than that in which the plan's headquarters are located, please give approximate breakdown of persons served, by State. *(Use separate sheet if necessary)*

STATE	NO. OF PERSONS	STATE	NO. OF PERSONS

F. Income and Expenditures for year 1968 *(or latest completed fiscal year): (If unable to give exact figures, give best estimates — audited figures not necessary.)*

NOTE: Do not include income from Federal Government under Medicare and reimbursable expense of providing service to Medicare beneficiaries.

ITEM	AMOUNT
1. Income *(Receipts)* (a) Subscriber dues, employer (ee) contributions, etc.	
(b) Income from fees or charges for health services	
(c) Investment and other income	
(d) Total income (a+b+c)	
2. Expenditures for health care benefits directly provided or paid for by plan. *(DO NOT ENTER under (a)–(k) any premiums paid to Blue Cross-Blue Shield, an insurance company or other health insurance organization for health benefits.) (Plans providing service through own hospital or clinic, see alternate F.2, below.)* (a) Hospital care	
(b) Physician service *(including office X-ray and lab.)*	
(c) Dental care	
(d) Drugs outside hospital	
(e) Visiting nurse service	
(f) Private duty nursing service	
(g) Eyeglasses and eye examinations *(not included under b)*	
(h) Nursing home care	
(i) Appliances *(artificial limbs, braces, etc.)*	
(j) Other health services or supplies *(specify)*	
(k) Total (a through j)	
3. Other benefit expenditures (a) Premiums paid to Blue Cross-Blue Shield, insurance company or other carrier for health benefit coverage	
(b) Cash benefits *(disability, death, survivor, retirement, etc.)* including any premium paid for same	
4. Administrative expense	
5. Total expenditures (2(k)+3+4)	
6. Surplus or deficit for year *(total income minus total expenditures)*	
Alternate F.2. Plans providing service directly through own hospital, and/or clinic or health center, may prefer to give the following alternative breakdown of health benefit expenditures: (a) Hospital care, exclusive of physicians and dentists	
(b) Total salaries paid to physicians	
(c) Total salaries paid to dentists	
(d) All other clinic salaries and wages	
(e) Cost of prescribed drugs for clinic patients	
(f) Cost of eyeglasses for clinic patients	
(g) All other expenses of clinic	
(h) Total expense for hospital care and operating clinic or health center	

G. If possible, please provide data on or an estimate of the breakdown of expenditures for health care benefits, *(as shown in item F)* as between persons under age 65 and aged 65 and over.

	TOTAL FOR ALL PERSONS	FOR PERSONS UNDER AGE 65	FOR PERSONS AGED 65 AND OVER*
All Health Care Benefits			
Hospital Care			
All Other Types of Care			

*Do not include expenses for which the plan is reimbursed under medicare

H. Information on arrangements for drugs and eyeglasses:
If your plan includes drugs and/or eyeglasses in its prepayment program, or makes these available to covered persons, please briefly describe arrangements below *(or use separate sheet, if necessary)*:

DRUGS

EYEGLASSES

I. Further information on program in general:
To correctly interpret the data you have provided, it is essential that we have a clear idea of the nature of your plan, how it is organized and financed, what benefits are provided and how. To that end, please give any further description of your plan that you think is necessary.

PLEASE ENCLOSE COPY OF LATEST AVAILABLE ANNUAL REPORT AND FINANCIAL STATEMENT, PAMPHLETS DESCRIBING BENEFITS, PERSONS ELIGIBLE, SUBSCRIBER CHARGES, EMPLOYER(EE) CONTRIBUTIONS, FACILITIES, ETC.

NAME AND TITLE OF PERSON PREPARING THIS REPORT

NAME	TITLE

PLEASE RETURN TO:

Louis S. Reed
Private Health Insurance Studies
Office of Research and Statistics
Social Security Administration

Department of Health, Education, and Welfare
Washington, D.C. 20201

(Use franked envelope or label; neither requires postage.)

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX C

Community Group Practice Plans

The four principal Kaiser Foundation Health plans together have more than 1.8 million practicipants. Each plan is autonomous to a large degree. Each has its own hospital or hospitals (more than twelve in all) and various ancillary clinics. The physicians of each plan are independently organized as a partnership or incorporated association and provide service to the plan at a negotiated rate per participant. The Kaiser Plan of Northern California serves largely the Bay area and Sacramento. The plan in Southern California serves the Los Angeles and San Diego areas. The plan in Oregon serves the Portland metropolitan area. The plan in Hawaii serves Honolulu and the Island of Oahu.

All of the plans are organized as nonprofit organizations. In the last analysis all are controlled by a board of directors consisting of Kaiser Company executives. There is no formal representation of the persons served.

As of January 1, 1968, the Kaiser system took over the operation of a community group practice plan in Cleveland, formerly known as the Community Health Foundation of Cleveland. This plan serves about 33,000 persons in the Cleveland area. The plan contracts with a group of physicians organized as a partnership or association who provide care in the plan's two health centers.

In January 1969 the Kaiser Health Foundation Plan started a new plan in Denver, Colorado.

The Health Insurance Plan of Greater New York (HIP) is a nonprofit organization controlled by a self-perpetuating board of directors composed of individuals selected to represent the general community and the subscribing public. It serves approximately 750,000 persons, many of whom are New York City employees and their dependents. The plan provides comprehensive physician service to its subscribers through 31 contracting medical groups. These groups in all but a few cases are organized as physician partnerships; each group is paid a set amount monthly for every participant who has elected to receive care from the group. HIP as yet does not provide hospital care to any large number of its subscribers (though it aims to do so in the future). Subscribers, how-

TABLE C–1.—Enrollment and income of nine large community group practice plans, 1950–68

[In thousands]

Year	Kaiser Health Foundation Plans						Health Ins. Plan of Gtr. N.Y.	Group Health Cooperative, Seattle, Wash.	Community Health Association, Detroit, Mich.	Group Health Association, Wash., D.C.
	Total	Northern California	Southern California	Oregon	Hawaii [1]	Kaiser Community Health Foundation, Cleveland, Ohio [2]				
	Enrollment									
1950	154	120	20	14	----	----	255	21	----	20
1951	244	160	67	17	----	----	287	24	----	19
1952	283	188	76	19	----	----	375	27	----	19
1953	402	240	140	22	----	----	392	36	----	20
1954	478	278	178	22	----	----	415	37	----	20
1955	524	302	199	23	----	----	471	38	----	21
1956	556	315	218	23	----	----	497	42	----	22
1957	575	317	234	24	----	----	528	45	----	22
1958	618	337	245	30	6	----	548	49	----	23
1959	690	358	273	37	22	----	560	54	----	34
1960	808	399	321	49	39	----	590	61	[3]	46
1961	881	421	365	55	40	----	632	63	9	[4] 49
1962	941	445	393	59	44	----	662	65	40	[4] 49
1963	1,035	480	442	65	48	----	680	69	59	[4] 51
1964	1,168	544	488	72	52	12	694	76	69	[4] 54
1965	1,347	646	549	81	53	18	[5] 673	85	71	[4] 57
1966	1,399	716	512	87	59	25	[5] 672	92	78	[4] 60
1967	1,699	803	695	103	67	31	[5] 682	101	79	69
1968	1,868	878	771	113	73	33	[5] 694	111	77	70
	Income [6]									
1950	$4,100	$3,351	[7] $320	$430	----	----	$7,357	$1,363	----	$825
1951	6,028	4,404	1,076	547	----	----	8,439	1,693	----	642
1952	7,720	5,797	1,233	690	----	----	10,218	1,729	----	947
1953	10,488	7,162	2,468	858	----	----	12,386	1,820	----	982
1954	20,508	10,124	9,436	948	----	----	14,941	1,976	----	1,008
1955	24,011	11,514	11,477	1,021	----	----	16,011	2,130	----	1,306
1956	27,430	12,883	13,447	1,101	----	----	18,009	2,346	----	1,434
1957	29,095	14,293	13,587	1,215	----	----	18,820	2,536	----	1,134
1958	35,796	18,564	15,732	1,462	$39	----	19,626	2,884	----	1,238
1959	42,846	22,064	17,984	1,888	909	----	20,177	3,336	----	1,532
1960	52,391	26,336	21,475	2,686	1,894	----	21,181	4,000	----	2,414

1961	61,333	30,181	25,253	3,382	2,517	----------	22,882	4,846	$328	[8] 3,511
1962	70,411	33,731	29,490	4,101	3,089	----------	28,319	5,180	2,580	[8] 4,033
1963	80,018	37,415	34,481	4,688	3,434	----------	30,288	5,550	4,325	[8] 4,719
1964	91,762	42,238	39,652	5,414	3,993	$465	31,240	6,506	5,258	[8] 5,674
1965	106,466	49,251	45,285	6,287	4,278	1,365	[19] 31,999	7,496	5,998	[8] 6,485
1966	123,717	58,581	51,039	7,078	4,766	2,253	[19] 30,085	8,862	6,428	[9] 3,815
1967	152,696	72,630	63,350	8,529	5,226	2,961	[10] 31,190	10,988	7,203	5,004
1968	180,499	87,433	75,843	10,606	7,055	3,562	[19] 30,709	13,184	7,382	5,583

[1] Began operation November 15, 1958.
[2] Began operation July 1, 1964; become a Kaiser Foundation plan in January 1969.
[3] Less than 500.
[4] As of September 30.
[5] Does not include enrollees under welfare and Medicaid programs. The number of such persons enrolled was 16,000 in 1965, 29,000 in 1966, 74,000 in 1967, and 84,000 in 1968.
[6] Includes any income from direct charges to members and any investment income, but excludes income from Social Security Administration under Medicare for the pro viding service to Medicare beneficiaries.
[7] Estimated.
[8] Year ending September 30.
[9] Decrease due to use of local Blue Cross plan to pay hospitals.
[10] Does not include income received from government agencies for welfare and Medicaid recipients, which amounted to $1,200,000 in 1965, $1,746,000 in 1966, $4,924,000 in 1967, and $6,640,000 in 1968.

ever, must have hospital insurance through Blue Cross, an insurance company or other acceptable source.

The Community Health Association (CHA) of Detroit, with some 77,000 participants, provides services through a hospital and five outlying clinics, owned by an affiliated nonprofit group. Service is provided by a full-time salaried medical staff. CHA serves a five county area of Detroit. Almost all subscribers are members of the United Auto Workers. The plan is controlled by a board of directors composed of community leaders.

Group Health Association, Inc., with approximately 70,000 enrollees, serves persons in the Washington, D.C. metropolitan area through its own salaried medical staff housed in two clinics. The plan does not have its own hospital and uses several hospitals in which its physicians have privileges. The majority of those served are Federal employees and annuitants and their dependents who have selected this plan under the Federal Employees Health Benefits program. The plan is controlled by a board of nine persons elected by the subscribers.

Group Health Cooperative of Puget Sound has 111,000 members. Its salaried medical staff provides service in the plan's hospital and central medical clinic and three ancillary clinics. The plan's Board is elected by members of the cooperative.

APPENDIX D

APPENDIX D.—Single State and multi-State plan enrollment, by State of plan headquarters and of enrollee residence

Region and State	All plans			Single State plans		Multi-State plans		
	Plans	Enrollment (in thousands)		Plans	Enrollment (in thousands)	Plans	Enrollment (in thousands)	
		By plan headquarters	By residence				By plan headquarters	By residence
United States	482	12,203.5	12,203.5	454	9,266.5	28	2,937.0	2,937.0
New England	19	61.5	206.1	19	61.5			144.6
Maine	1	1.2	6.5	1	1.2			5.3
New Hampshire			4.0					4.0
Vermont			9.0					9.0
Massachusetts	13	51.6	140.6	13	51.6			89.0
Rhode Island	1	2.4	11.7	1	2.4			9.3
Connecticut	4	6.3	34.3	4	6.3			28.0
Middle Atlantic	194	4,661.3	4,977.5	186	4,235.7	8	425.6	741.8
New York	144	3,952.7	3,902.4	138	3,568.1	6	384.7	334.3
New Jersey	17	114.8	175.7	16	90.0	1	24.7	85.7
Pennsylvania	33	593.8	899.4	32	577.6	1	16.2	321.8
East North Central	61	1,160.4	1,168.1	64	557.0	4	603.3	611.1
Michigan	4	102.6	158.5	4	102.6			55.9
Ohio	24	736.3	493.2	21	159.9	3	576.3	333.3
Illinois	18	206.7	323.4	17	179.7	1	327.0	143.7
Indiana	3	12.9	64.9	3	12.9			52.0
Wisconsin	19	101.9	128.1	19	101.9			26.2
West North Central	37	291.7	366.6	32	189.4	5	102.3	177.2
Minnesota	11	86.9	79.2	9	43.4	2	43.6	35.8
Iowa	5	14.3	41.3	5	14.3			27.0
Missouri	17	153.0	147.0	14	94.3	3	58.7	52.7
North Dakota			4.5					4.5
South Dakota	1	7.0	10.9	1	7.0			3.9
Nebraska	2	1.9	26.0	2	1.9			24.1
Kansas	1	28.5	57.7	1	28.5			29.2
South Atlantic	40	1,727.5	616.3	33	138.1	7	1,589.5	478.2
Delaware	1	10.5	14.3	1	10.5			3.8
Maryland	6	412.3	81.2	4	20.4	2	392.0	60.8
District of Columbia	9	1,212.8	78.9	5	36.5	4	1,176.3	42.4
Virginia	9	32.5	79.7	8	11.3	1	21.2	68.4
West Virginia	2	20.3	204.5	2	20.3			184.2
North Carolina	4	3.4	33.4	4	3.4			30.0
South Carolina			13.7					13.7
Georgia	4	22.2	59.3	4	22.2			37.1
Florida	5	13.5	51.3	5	13.5			37.8
East South Central	6	56.2	266.3	6	56.2			210.1
Kentucky	1	2.6	85.8	1	2.6			83.2
Tennessee	1	25.2	82.8	1	25.2			57.6
Alabama	3	27.3	85.3	3	27.3			58.0
Mississippi	1	1.1	12.4	1	1.1			11.3
West South Central	24	63.8	223.1	23	54.1	1	9.6	169.0
Arkansas	3	11.7	34.7	2	2.0	1	9.6	32.7
Louisiana	5	25.8	56.4	5	25.8			30.6
Oklahoma	3	2.5	28.6	3	2.5			26.1
Texas	13	23.8	103.4	13	23.8			79.6
Mountain	24	171.9	223.7	23	128.9	1	43.0	94.8
Montana			10.5					10.5
Idaho	4	2.2	11.2	4	2.2			9.0
Wyoming			10.0					10.0
Colorado	6	70.7	89.3	6	70.7			18.6
New Mexico	1	.7	8.2	1	.7			7.5
Arizona	3	22.8	42.6	3	22.8			19.8
Utah	6	49.5	22.2	5	6.5	1	43.0	15.7
Nevada	4	26.0	29.7	4	26.0			3.7
Pacific	70	4,009.2	4,155.7	68	3,845.6	2	163.8	310.1
Washington	7	246.4	288.5	7	246.4			42.1
Oregon	8	241.6	242.7	7	128.7	1	113.0	114.0
California	35	3,337.3	3,439.3	34	3,286.6	1	50.8	152.7
Alaska			.5					.5
Hawaii	20	183.9	184.7	20	183.9			.8

APPENDIX E

APPENDIX E.—Enrollment for specified benefits of persons under age 65, by State of residence

[In thousands]

Region and State	Estimated enrollment under age 65		
	Hospital care	Surgery	In-hospital medical
United States	6,774.6	8,278.9	8,025.4
New England	148.0	98.0	131.3
Maine	6.0	5.9	5.6
New Hampshire	4.6	4.5	4.3
Vermont	10.1	6.8	9.4
Massachusetts	88.9	50.7	76.9
Rhode Island	7.3	6.6	6.8
Connecticut	31.3	23.4	28.3
Middle Atlantic	1,711.9	3,536.0	3,224.6
New York	855.1	2,925.4	2,684.6
New Jersey	96.5	80.3	77.4
Pennsylvania	760.4	530.4	462.6
East North Central	1,028.2	772.2	926.1
Michigan	151.5	141.3	139.1
Ohio	473.1	244.7	412.0
Illinois	261.7	203.7	201.9
Indiana	68.1	60.2	62.1
Wisconsin	118.8	122.3	111.1
West North Central	272.5	300.3	298.4
Minnesota	77.5	78.7	75.1
Iowa	45.8	45.0	42.9
Missouri	48.8	92.9	88.5
North Dakota	4.6	4.5	4.3
South Dakota	11.8	11.8	11.1
Nebraska	26.9	21.3	23.1
Kansas	57.1	46.1	53.5
South Atlantic	461.0	475.9	476.8
Delaware	3.5	3.5	3.3
Maryland	43.5	40.5	62.7
District of Columbia	5.0	48.2	43.6
Virginia	60.5	69.0	68.4
West Virginia	202.3	180.2	169.8
North Carolina	37.6	36.2	35.0
South Carolina	15.1	14.5	14.1
Georgia	38.4	29.9	36.1
Florida	55.0	43.5	43.8
East South Central	273.7	242.3	229.6
Kentucky	78.3	71.8	73.4
Tennessee	91.1	86.9	58.6
Alabama	91.2	71.1	85.4
Mississippi	13.1	12.5	[1]12.3
West South Central	169.3	172.0	181.6
Arkansas	37.8	37.2	35.4
Louisiana	20.7	43.6	42.0
Oklahoma	29.7	22.6	27.9
Texas	81.0	68.6	76.3
Mountain	157.8	146.5	147.8
Montana	10.3	10.2	9.7
Idaho	9.6	9.5	9.0
Wyoming	9.4	9.3	8.8
Colorado	38.2	37.5	35.7
Mew Nexico	8.8	8.7	8.2
Arizona	29.3	19.2	27.4
Utah	18.1	18.0	17.0
Nevada	34.2	34.0	32.0
Pacific	2,552.2	2,535.3	2,409.2
Washington	185.1	183.6	173.4
Oregon	124.3	123.1	116.5
California	2,130.2	2,117.6	2,014.7
Alaska	[1]	[1]	[1]
Hawaii	112.6	111.0	104.6

[1] Less than 0.5.

APPENDIX F

Plans in Puerto Rico

There were six plans in Puerto Rico that responded to the survey and that were active in 1968. These plans were all of the employer-employee-union type and had a total enrollment of 103,460 persons (table F-1). Of these plans, 4 were operated by union-employer welfare funds and included 65 percent of the total enrollment. One plan was an employer or employer association which covered approximately 700 persons. The remaining plan was an employee association with an enrollment of 35,000 persons—34 percent of the total. Only one of the six plans, with an enrollment of 36,000 persons, provided services through group practice arrangements.

As can be seen from the table, only 2 percent of the total persons enrolled by these plans were age 65 and over. Four of the six plans covered dependents and the enrollment of these plans amounted to 103,000 persons or 99.6 percent of the total.

Table F-2 shows the number of plans providing specified benefits and the number of persons covered for these benefits. Of the six plans, five provided hospital care to 72,000 persons. Physician services, except for home calls, were covered by most of the plans with approximately 70 percent of all enrollees covered for these services. Only 400 persons were covered for physician home visits.

Four plans with an enrollment of 37,000 persons covered drugs outside of the hospital on a prepayment basis. Dental care was provided by two plans covering 32,000 persons. Refractions were covered by three plans with 69 percent of the total enrollment, while eyeglasses were provided to only 400 persons.

TABLE F–1.—Puerto Rico: Plans and enrollment, by enrollee age and type of plan

Type of plan	All ages								By age		
	Subscribers		Dependents		Total				Enrollment		65 plus as percent of total
	Number of plans	Enrollment	Number of plans	Enrollment	Number of plans	Percentage distribution	Enrollment	Percentage distribution	Under age 65	Over age 65	
All plans	6	32,286	4	71,174	6	100.0	103,460	100.0	101,106	2,354	2.3
Community group practice											
Community individual practice											
Employer-employee-union group practice	1	6,000	1	30,000	1	16.7	36,000	34.8	36,000		
Union employer welfare fund	1	6,000	1	30,000	1	16.7	36,000	34.8	36,000		
Employer or employer association											
Union											
Employee association											
Employer-employee association											
Employer-employee-union individual practice	5	26,286	3	41,174	5	83.3	67,460	65.2	65,106	2,354	2.3
Union employer welfare fund	3	5,613	1	25,935	3	50.0	31,548	30.5	31,539	9	(1)
Employer or employer association	1	152	1	522	1	16.7	674	.7	667	7	(1)
Union											
Employee association	1	20,521	1	14,717	1	16.7	35,238	34.0	32,900	2,338	2.2
Employer-employee association											
Private group medical clinic											
Private group dental clinic											
Dental service corporation											

[1] Less than 0.05.

TABLE F–2.—Puerto Rico: Plans and enrollment, by type of service and enrollee age

Type of benefit	All ages								By age		
	Subscribers		Dependents		Total				Enrollment		Age 65 and over as percent of total
	Number of plans	Enrollment	Number of plans	Enrollment	Number of plans	Percentage distribution	Enrollment	Percentage distribution	Under age 65	Over age 65	
Any benefit	6	32,286	4	71,174	6	100.0	103,460	100.0	101,106	2,354	2.3
Hospital care	5	27,099	3	45,239	5	83.3	72,338	69.9	69,984	2,354	3.3
Physician service:											
Surgical-obstetrical	5	33,099	3	39,239	5	83.3	72,338	69.9	69,984	2,354	3.3
In-hospital medical visits	4	26,896	3	45,239	4	66.7	72,135	69.7	69,785	2,350	3.3
X-ray and laboratory outside hospital	5	27,099	3	45,239	5	83.3	72,338	69.9	69,984	2,354	3.3
Office and clinic visits	5	27,099	3	45,239	5	83.3	72,338	69.9	69,984	2,354	3.3
Home visits	2	426			2	33.3	426	.4	417	9	2.1
Dental care	2	6,223	1	30,000	2	33.3	36,223	35.0	36,218	5	(1)
Drugs outside hospital	4	6,578	2	30,522	4	66.7	37,100	35.9	37,084	16	(1)
On prepayment basis	4	6,578	2	30,522	4	66.7	37,100	35.9	37,084	16	(1)
On other basis											
Visiting nurse service											
Special duty nursing											
Hospital											
Home											
Vision care:											
Refractions	3	26,744	2	44,717	3	50.0	71,461	69.1	69,118	2,343	3.3
Eyeglasses	2	426			2	33.3	426	.4	417	9	2.1
On prepayment basis	2	426			2	33.3	426	.4	417	9	2.1
On other basis											
Nursing home care											
Appliances											
Other services											

[1] Less than 0.05.

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